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Crazy (Mental Illness Under the ADA)

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Jane Byeff Korn*

This Article examines how people with mental disabilities and mental illnesses have been treated under the Americans with Disabilities Act. Part I addresses the history of mental illness. It argues that while beliefs about the causes and content of mental illness have vacillated over time, the mentally ill have received consistently poor treatment throughout human history. Part II addresses present problems with the definition of mental illness, including how mental illness and mental disability are defined under the Americans with Disabilities Act.

Part III discusses the problems faced by people with mental illness today. The author argues the current state of the law affords little protection to persons with mental illness, despite the existence of the Americans with Disabilities Act. Part III gives particular attention to the problems employers face, and think they face, when trying to accommodate the mentally disabled in the workplace. Part IV examines the distinction between physical and mental disability. The author argues that the distinction between these two categories of illness is untenable: many "physical" disabilities have a cognitive component, and many "mental" disabilities have direct physical effects. In the context of the ADA, the author argues that the distinction is merely a font of useless litigation, and that the additional cost of addition coverage for mental disabilities would be slight.

In Part V, the author proposes a solution: eliminating the ADA's distinctions between mental and physical disabilities. The author argues that this would reduce the difficulties faced by the mentally disabled, and those whose disabilities are not easily categorized as either purely mental or purely physical, while not imposing any significant additional burden on employers.

On February 7, 2001, Robert W. Pickett fired several shots on the South Lawn of the White House.¹ Mr. Pickett was shot in the leg by the Secret Service. No one else was hurt although the incident raised questions about security at the White House. Newspaper articles about the incident routinely mentioned that Mr. Pickett had

* Professor of Law, University of Arizona, James E. Rogers College of Law. Many thanks to Barbara Atwood, Toni Massaro, and Gary Korn for their comments on prior drafts of this paper and to my research assistants, Catherine Dooley, Russell Esslinger, Abbe Goncharsky, and Matthew Parry. I also would like to thank the James E. Rogers College of Law for the research grants that allowed me to work on this paper.

1. Mr. Pickett was sentenced to three years in prison for these acts. After accepting a plea agreement, U.S. District Judge Henry H. Kennedy recommended that Mr. Pickett serve this term in a hospital prison. *White House Shooter Sentenced*, CNN.com, July 3, 2001, at <http://www.cnn.com/2001/LAW/07/31/whitehouse.shooting/index.html> (last visited Sept. 12, 2003).

a history of mental illness.² Although many physical illnesses can also be linked to behavioral changes,³ few news articles about similar incidents mention that the perpetrator had a "history of physical illness." Many may assume that the reason for this is that there is a correlation between mental illness and acts of violence and that no such correlation exists between acts of violence and physical illness. Yet, more than 95% of violent acts in our society are committed by people who are *not* mentally ill.⁴ In fact, gender (male) and age (younger) are more predictive of violence than mental illness.⁵ If the statistic that 95% of violent acts are committed by *non*-mentally ill people is true, then what justifies the disparate assumptions about, and treatment of, people with mental disabilities in our society?

Reactions to people with disabilities of all kinds include fear, pity, and admiration.⁶ People with disabilities are stereotyped as needy and inferior.⁷ Historically our society has isolated and segregated people with disabilities.⁸ Whatever stigma attaches to a

2. See, e.g., Allan Lengel, *Armed Man Arrested Outside White House: Officers Find Rifles, Pistol in Truck*, WASH. POST, Dec. 7, 2001, at A3; *News in Brief*, CHRISTIAN SCI. MONITOR, 24, Feb. 9, 2001; Matt Kelley, *Man Has Troubled History*, AUGUSTA CHRON., Feb. 8, 2001, at A01; Terence Hunt, *Gunman Shot at White House Indiana Accountant Wounded in Standoff, Tourists Evacuated; Bush Never in Danger*, CHI. SUN-TIMES, Feb. 8, 2001, at 1; *Gunman Nabbed Outside White House*, ROCKY MOUNTAIN NEWS (DENVER), Feb. 8, 2001, at 1A; *White House Gunman Passed Background Check*, CANADIAN PRESS, Feb. 8, 2001; Hope Yen, *Stigma Remains Barrier for Mentally Ill, Advocates Say*, PITTS. POST-GAZETTE, at B8, Mar. 7, 2000.

3. See, e.g., *Mental-Health Parity or Parody*, 39 MED. TRIB.: INTERNIST & CARDIOLOGIST EDITION 20, (1998) (citing studies indicating that persons with rheumatoid arthritis and a history of depression experienced more pain than those without the history and that diabetics who received psychotherapy had lower levels of depression and lower blood-glucose levels than those for whom the depression went untreated).

4. See American Psychiatric Association, *Fact Sheet: Violence and Mental Illness* (1998), available at http://www.psych.org/public_info/violence.pdf (last visited Sept. 18, 2003) [hereinafter *APA Fact Sheet*]; see also KAN. CITY STAR, April 15, 2000, available at 2000 WL 7728422 (quoting the statement of the American Psychiatric Association). Even in those cases in which someone with a mental illness does commit a violent act, the causal connection is not clear, i.e., whether the mental illness caused the act of violence.

5. LIZ SAYCE, *FROM PSYCHIATRIC PATIENT TO CITIZEN, OVERCOMING DISCRIMINATION AND SOCIAL EXCLUSION* 34 (2000) (noting that being young and male and using alcohol and drugs are more predictive of violence than mental illness); Rohan Ganguli, M.D., Editorial, PITTS. POST-GAZETTE, March 18, 2000.

6. Matthew Diller, *Dissonant Disability Policies: The Tensions Between the Americans with Disabilities Act and Federal Disability Benefit Programs*, 76 TEX. L. REV. 1103, 1003 (1998) (discussing some of the reactions to people with disabilities).

7. JEROME E. BICKENBACH, *PHYSICAL DISABILITY AND SOCIAL POLICY* 143 (1993).

8. See, e.g., Lisa Eichhorn, *Major Litigation Activities Regarding Major Life Activities: The Failure of the "Disability" Definition in the Americans with Disabilities Act of 1990*, 77 N.C. L. REV. 1405, 1415 (1999); Jonathan C. Drimmer, Comment, *Cripples, Overcomers and Civil Rights*:

physical disability, however, most scholars agree that people with mental disabilities are more feared, more stigmatized, discriminated against more often, and are seen as more likely to commit acts of violence than are people with physical disabilities.⁹ People with mental disabilities are seen as shameful, dangerous, and irresponsible,¹⁰ and discrimination against people with mental disabilities is widespread.¹¹

Studies indicate that 28% of adults in the United States have a diagnosable mental or addictive disorder.¹² In the United States, 70–90% of persons classified as mentally disabled were unemployed and not seeking work.¹³ In contrast, employment rates for the general population indicate that 70–90% are employed.¹⁴ Moreover, recent studies indicate that people with mental disabilities can work, and that working may decrease symptoms.¹⁵

While much has been written about the serious problems confronting people with mental disabilities, including civil commitment, competency determinations,¹⁶ the insanity defense,¹⁷ and the right to refuse treatment,¹⁸ little attention has focused on employment discrimination against people with mental disabilities. The Americans with Disabilities Act ("ADA"),¹⁹ enacted in 1990 to protect people with both physical and mental disabilities, has

Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities, 40 U.C.L.A. L. REV. 1341, 1359 (1993).

9. See, e.g., Susan Stefan, *Delusions of Rights: Americans with Psychiatric Disabilities, Employment Discrimination and the Americans with Disabilities Act*, 52 ALA. L. REV. 271, 273–74 (2000); Stephanie Proctor Miller, Comment, *Keeping the Promise: The ADA and Employment Discrimination on the Basis of Psychiatric Disability*, 85 CAL. L. REV. 701, 705 (1997).

10. SAYCE, *supra* note 5, at 60.

11. See, e.g., Bruce G. Link et al., *Stigma as a Barrier to Recovery: The Consequences of Stigma for the Self-Esteem of People with Mental Illnesses*, 52 PSYCHIATRIC SERVICES 1621 (Dec. 2001); Stefan, *supra* note 9, at 272. Moreover, without making a distinction between kinds of disabilities, the preamble to the Americans with Disabilities Act ("ADA"), for example, indicates that prior to its enactment there was widespread discrimination against the forty-three million disabled Americans. 42 U.S.C. § 12101(a)(1) (1994).

12. RICHARD J. BONNIE & JOHN MONAHAN, *MENTAL DISORDER, WORK DISABILITY, AND THE LAW* 15 (1997).

13. SAYCE, *supra* note 5, at 19.

14. *Id.*; see also BONNIE & MONAHAN, *supra* note 12, at 18.

15. SAYCE, *supra* note 5, at 19; BONNIE & MONAHAN, *supra* note 12, at 25.

16. See, e.g., SUSAN STEFAN, *UNEQUAL RIGHTS, DISCRIMINATION AGAINST PEOPLE WITH MENTAL DISABILITIES AND THE AMERICANS WITH DISABILITIES ACT* (2001).

17. Michael L. Perlin, *"The Borderline Which Separated You From Me": The Insanity Defense, The Authoritarian Spirit, The Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375 (1997).

18. See, e.g., Susan Stefan, *supra* note 9.

19. 42 U.S.C. 12101 et seq. (1994).

proven largely ineffective in the eyes of advocates of the disabled.²⁰ Much has been written about the failure of the ADA to provide adequate protection to people with physical disabilities, and much of the criticism involves the definition of the term "disability" in the statute and its interpretation by the courts.²¹ On the other hand, many employers are becoming increasingly concerned about what they see as the comprehensive reach of the ADA and the growing threat of litigation by someone with a disability.

This Article examines how people with mental disabilities, particularly mental illness,²² have fared under the ADA. The difficulties caused by the problem of deciding what is a disability under the ADA are present whether the disability is physical or mental. In spite of this commonality, this Article concludes that not only have people with mental disabilities fared no better than

20. See, e.g., Ruth Colker, *The Americans with Disabilities Act: A Windfall for Defendants*, 34 HARV. C.R.-C.L. L. REV. 99, 100 (1999); Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621 (1999). See also Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth": *Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 6 (1999).

21. See, e.g., Peter David Blanck & Mollie Weighner Marti, *Attitudes, Behavior and the Employment Provisions of the Americans with Disabilities Act*, 42 VILL. L. REV. 345 (1997) (taking the position that the definition of a disability under the ADA is one of the most "contentious aspects of disability law"); Robert L. Burgdorf, Jr., "Substantially Limited" Protection From Disability Discrimination: *The Special Treatment Model and Misconstructions of the Definition of Disability*, 42 VILL. L. REV. 409 (1997) (arguing that using the term substantially limited, the courts have narrowly interpreted the definition of disability); Crossley, *supra* note 20, at 621 (addressing interpretation of the term disability in the ADA); Drimmer, *supra* note 8; Eichhorn, *supra* note 8; Michelle Friedland, *Not Disabled Enough: The ADA's "Major Life Activity" Definition of Disability*, 52 STAN. L. REV. 171 (1999) (arguing that the ADA needs new definitions for disability).

22. My primary focus in this Article is on mental illness and most of the arguments in the Article are made in reference to mental illness, although they may also be applicable to other types of mental disabilities, such as developmental delays. In Part III, *infra*, I discuss the difficulty in defining mental illness. For now, I use one of the definitions used by the American Psychiatric Association that "Mental illness is an illness that affects or is manifested in a person's brain. It may impact on the way a person thinks, behaves, and interacts with other people." *What is Mental Illness*, American Psychiatric Association, Public Information, available at http://www.psych.org/public_info/what_is_mi.cfm (last visited Sept. 12, 2003). Mental illness is not one illness. It encompasses many different diseases. "Some of the commonly known psychiatric disorders are depression; manic depression (also known as bipolar disorder); anxiety disorders, including specific phobias (such as fear of heights), social phobia, panic disorder, agoraphobia, obsessive-compulsive disorder, and generalized anxiety disorder; schizophrenia and other psychotic disorders, such as delusional disorder; substance abuse and disorders related to substance abuse; delirium; dementia, including Alzheimer's disease; eating disorders, such as bulimia and anorexia; sleep disorders; attention-deficit/hyperactivity disorder; learning disorders; sexual disorders; dissociative disorders, such as multiple personality disorder; and personality disorders, such as borderline personality disorder and antisocial personality disorder." *Id.*

people with physical disabilities, but that they are, in fact, in an even worse position.²³ In addition, I posit that the ADA's failure to provide adequate protection for people with mental disabilities is caused by three congruent factors. First, there is a deeply entrenched stigma attached to mental disabilities, including a belief that there is a significant correlation between mental illness and violent acts. Second, the ADA contains subtle distinctions between physical and mental disabilities that further stigmatize people with mental disabilities and may result in more discrimination against them. Third, both the courts and the EEOC have encountered great difficulty in eliminating their own stereotypes about people with disabilities, in particular, the vision of a disability as limited to an observable, physical one. Part I briefly discusses the historical treatment of people with mental illness. Part II examines the difficulty in defining mental illness. Part III discusses the stigma and other problems faced by people with mental illness today. This section also addresses employers' difficulties in attempting to accommodate someone with a mental illness. Part IV explores the distinction traditionally made between physical and mental disabilities. In addition to documenting the ramifications of this dividing line for people who are mentally disabled, arguments for and against this dividing line are analyzed. I conclude that the distinction between mental and physical disabilities is no longer warranted (if it ever was) and explore the role that this distinction continues to play in furthering the problems faced by the people the ADA was designed to protect. Finally, Part V proposes eliminating the ADA's distinctions between mental and physical disability. While this would not eliminate all of the problems faced by people with mental disabilities, it would reduce the difficulties caused by the long held belief that mental disabilities are somehow different, less real, and less worthy of belief than physical ones.

23. While we may believe that the ADA has protected people with mental disabilities, this is not the case. "There is, in short, a huge gap between what mental disability law appears to be, and what it actually is." Perlin, *supra* note 20, at 25.

I. BRIEF HISTORY OF TREATMENT OF MENTAL ILLNESS

Mental illness has been observed throughout the ages,²⁴ but beliefs about the causes and efficacious treatments of mental illness have shifted over time.²⁵ The first culture to differentiate between mental and physical illness is lost in history, but we do know that even the early Greeks and Romans made such a distinction.²⁶

For most of our history, people with mental disabilities were cared for by their families,²⁷ but this home care may well have been less than idyllic.²⁸ Refuting the vision of people with disabilities "being permitted to gambol on the village green," one historian recounts evidence that people with mental disabilities were not only abused, but were also frequently confined by the use of chains.²⁹ In the United States, "distracted persons," a term formerly used to mean persons who were mentally ill, were often confined to "strong-houses," which were, in actuality, tiny structures built for one patient that were about five-by-seven foot in size. People with mental illnesses were treated, if at all, with the traditional medical treatment of their time, including bleeding, purging, and the giving of emetics.³⁰

Hospitalization for persons with mental disorders began during the eighteenth century and rapidly gained popularity. At New York Hospital, the psychiatric building was designated "Lunatic Asylum" and the first psychiatric hospital was founded "to make provision

24. FRANZ G. ALEXANDER, M.D. & SHELDON T. SELESNICK, M.S., *THE HISTORY OF PSYCHIATRY: AN EVALUATION OF PSYCHIATRIC THOUGHT AND PRACTICE FROM PREHISTORIC TIMES TO THE PRESENT* 3 (1966); MICHAEL H. STONE, *HEALING THE MIND, A HISTORY OF PSYCHIATRY FROM ANTIQUITY TO THE PRESENT* 3 (1997).

25. See, e.g., ALEXANDER & SELESNICK, *supra* note 24, at 17–150.

26. GEORGE MORA, *Early American Historians of Psychiatry: 1910–1960* in *DISCOVERING THE HISTORY OF PSYCHIATRY* 55–67 (Mark S. Micale & Roy Porter eds., 1994) (tracing the history of psychiatry to Greco-Roman culture); GEORGE ROSEN, *MADNESS IN SOCIETY: CHAPTERS IN THE HISTORICAL SOCIOLOGY OF MENTAL ILLNESS* 71–83 (1968).

27. GERALD BROB, *THE MAD AMONG US, A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL* 6 (1994); EDWARD SHORTER, *A HISTORY OF PSYCHIATRY, FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC* 2 (1997); Susan Kerr, *The Application of the Americans with Disabilities Act to the Termination of the Parental Rights of Individuals with Mental Disabilities*, 16 J. CONTEMP. HEALTH L. & POL'Y 387, 389 (2000).

28. SHORTER, *supra* note 27, at 7. In England, persons with mental disabilities might be at home or in a workhouse or poorhouse. The treatment of people with mental disabilities was no better in this country. Some people with disabilities in this country were placed in "little strong-houses for individual patients." *Id.*

29. *Id.* at 2. See also Kerr, *supra* note 27, at 390.

30. SHORTER, *supra* note 27, at 17.

for the Support and Maintenance of Idiots [sic], Lunatics and other Persons of Unsound Minds.”³¹ According to one scholar, the history of psychiatry began in the custodial asylum,³² which served as a way for families to transfer the care and confinement of someone with a mental disability from their home and in their company, to somewhere and someone else.³³ By the end of the eighteenth century, however, people began to believe that institutionalization would not only serve to segregate and warehouse people with mental disabilities, it might also cure the person of a mental illness.³⁴ One doctor noted:

Madness is . . . as manageable as many other distempers, which are equally dreadful and obstinate, and yet are not looked upon as incurable; such unhappy objects ought by no means to be abandoned, much less shut up in loathsome prisons as criminals or nuisances to the society.³⁵

In other words, the asylums of this era were supposed to cure patients, rather than to serve merely as an alternative to living with and being cared for by their families. The cure came from a form of “moral therapy,” in which the patient was given some productive activity, a good diet, and doctors tried to promote hope. According to at least one historian, this is the beginning of formal, psychological intervention.³⁶

Those who had what were considered to be “nervous disorders” or allegedly less serious mental illnesses, were treated quite differently.³⁷ Nervous disorders were treated by a traditional medical doctor, although they have become the usual patients of modern day psychologists and psychiatrists.³⁸ Many people diagnosed with a nervous disorder were apparently wealthy enough to seek treatment at a “spa.”³⁹ One young woman was brought to a spa with symptoms “that usually accompany the virgin disease.”⁴⁰ These symptoms included weakness in her wrists, facial discoloring, little

31. *Id.* (quoting Sven Torgersen, *Genetic Factors in Anxiety Disorders*, 40 ARCHIVES GEN. PSYCHIATRY 1085, 1085–1089 (1983)).

32. *Id.* at 8.

33. *Id.* at 10.

34. See SHORTER, *supra* note 27, at 24.

35. *Id.* at 10.

36. *Id.* at 22.

37. See SHORTER, *supra*, note 27, at 24.

38. *Id.*

39. *Id.*

40. SHORTER, *supra*, note 27, at 24.

appetite and "vapors and strange fits."⁴¹ She was allegedly cured by seven weeks of bathing and drinking the waters. Her doctor believed that "giving her to a good husband" would prevent a relapse.⁴²

Physicians also distinguished between serious mental illnesses and less serious ones.⁴³ One doctor who treated patients outside the spa setting wrote that nervous disorders were not the same as madness but were more like physical illness.⁴⁴ This became an enormously popular belief.⁴⁵ The person who was suffering from a nervous disorder, as opposed to "madness," was not to blame for having it. The main difference, however, between those who were sent to the asylum as opposed to those treated in a spa or by a private "nerve" doctor appears to have been wealth.⁴⁶ Those with the economic means to do so could be treated outside the asylum, thus effectively declaring that their problem was organic in nature. This allowed those with enough money to avoid the stigma of hospitalization for mental illness.⁴⁷

The treatment of mental illness in this country has varied depending on the current theory regarding causation. In the eighteenth century, mental illness was thought to be caused by something gone wrong in the body.⁴⁸ By the end of that century, the current theory about the cause of mental illness was considered a "matter of mind and spirit."⁴⁹ By the middle of the nineteenth century, the theory had again changed and mental illness was resolutely believed to be caused by a "brain disease."⁵⁰ Sigmund Freud and the psychoanalytical movement ended the brain disease theory and replaced it with psychoanalytical theory.⁵¹ The brain disease theory, in a different format, is now again in force.⁵²

41. *Id.* at 24. See also Perlin, *supra* note 20, at 6 (describing difference in modern day reactions to two people with mental illness, one poor and the other wealthy and famous).

42. SHORTER, *supra* note 27, at 24. For an interesting look at sexism in the history of mental illness, see VIVIAN BURR, GENDER AND SOCIAL PSYCHOLOGY 7-8 (1998); Nancy Tomes, *Feminist Histories of Psychiatry*, in DISCOVERING THE HISTORY OF PSYCHIATRY, 348-350 (Mack S. Micale & Roy Porter eds. 1994).

43. SHORTER, *supra* note 27, at 24.

44. *Id.*

45. *Id.* at 24-26.

46. See *Id.*

47. *Id.*

48. *Id.* at 44.

49. *Id.*

50. *Id.* at 45.

51. *Id.*

52. *Id.*

The historical treatment of mental illness also has a gendered component. Note that the vast majority of people burned alive as witches were women; the ratios vary from twenty to one to six to one.⁵³ More than one person has posited that those burned as witches might actually have been suffering some form of mental illness. Science replaced witchcraft as a dominant theme sometime in the nineteenth century, and this had a significant effect on women who were mentally ill; it gave new credibility to male scientific and medical experts. Women were not only excluded from these ranks,⁵⁴ but were also over represented in the newly established asylums of the nineteenth century.⁵⁵ The population of women in the asylums included those who were sexual nonconformists such as the "promiscuous," those who bore children out of wedlock, and those who were sexually assaulted or raped and traumatized by the event.⁵⁶

II. WHAT IS A MENTAL DISORDER?

A. Varying Definitions

The definition of a mental disorder or illness is elusive; it depends in part on whom you ask and it is also contextual.⁵⁷ "More than race and gender, mental illness is a disputed concept with ill defined boundaries."⁵⁸ Mental health can also be seen as a

53. JANE M. USSHER, WOMEN'S MADNESS: MISOGYNY OR MENTAL ILLNESS? 43 (1991).

54. *Id.* at 66.

55. *Id.* at 71.

56. *Id.* at 73.

57.

It is all right to be 'out of contact' if you are a young woman who ignores suggestive remarks from men as you walk along the street; it is all right (or at least it is no concern of a psychiatrist) if you hear supernatural voices in the course of a Pentecostal meeting; you may take off your clothes and dance at a hippie festival of joy and music, you may hector and dominate in the classroom or parade ground, you may refuse attention to onlookers if you are fishing, writing a PhD or meditating on St John of the Cross: but if you try these things at home, in the wrong kind of public place or on the observation ward of a mental institution, heaven help you because you are then 'mad,' 'mental' or eligible for some more technical diagnosis.

Id. at 135 (quoting Sedgewock, 1981:45). See also STONE, *supra* note 24, at 22; BONNIE & MONAHAN, *supra* note 12, at 13-15. For a discussion of the effect of labeling someone as mentally ill, see CAROL A. B. WARREN, THE COURT OF LAST RESORT, 46-48 (1982).

58. TOM CAMPBELL & CHRIS HEGINBOTHAM, MENTAL ILLNESS, PREJUDICE, DISCRIMINATION AND THE LAW 20 (1991).

continuum.⁵⁹ The question of what constitutes a mental illness has varied over time; in the not too distant past, both alcoholism and homosexuality were considered to be mental illnesses but are no longer considered as such.⁶⁰

The DSM⁶¹ defines a mental disorder as:

[A] clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.⁶²

A somewhat more lay definition of mental illness is “a term used for a group of disorders causing severe disturbances in thinking, feeling and relating. They result in substantially diminished capacity for coping with the ordinary demands of life.”⁶³ The one common trait of mental disorders is that they “all involve, or are presumed to involve, some disturbance of *mental* functioning, be it intellectual capacities, thought processes, emotions, or underlying motivations.”⁶⁴ Mental illness has also been defined as a diagnosable mental disorder “characterized by abnormalities in cognition,

59. Sharon Begley, *Is Everybody Crazy?*, Newsweek, Jan. 26, 1998, at 50.

60. CAMPBELL & HEGINBOTHAM, *supra* note 58, at 21.

61. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, xxi–xxii (4th ed. 1994) [hereinafter *DSM*].

62. *Id.* at xxi–xxii.

63. *About Mental Illness*, available at <http://www.compeer.org/1/a9.asp> (last visited Sept. 18, 2003) (Compeer is a non-profit program that matches community volunteers in supportive relationships with people who are receiving mental health treatment).

64. JOAN BUSFIELD, MEN, WOMEN, AND MADNESS, UNDERSTANDING GENDER AND MENTAL DISORDER 52 (1996).

emotion or mood, or the highest integrative aspects of behavior, such as social interactions or planning of future activities."⁶⁵

There are others, however, who would say that there is no such thing as mental illness.⁶⁶ Thomas Szasz argued, controversially, that the concept of mental illness is analogous to witchcraft. Just as earlier societies were firmly convinced that witches existed, we are firmly convinced that mental illness exists today. According to Szasz, we will one day find out that mental illness was an ill-conceived idea, just as was the idea of witchcraft.⁶⁷ Szasz posits that in the past physicians had two choices—they could label a person as ill or as a witch. Similarly, modern day physicians are similarly limited to two alternatives: organic illness or mental illness.⁶⁸ In support of this view of mental illness as a label for a disease that does not exist, others have pointed out that "[i]llness is in part an evaluative term defined by social convention and, more particularly, 'mental illness' embodies evaluative assumptions about acceptable social performance as well as the desirability of certain types of experience."⁶⁹ Some have suggested that the idea of mental illness has been manufactured in an attempt to control those who break the rules of society.⁷⁰ Others have a somewhat different view, and argue that mental illness really involves "diverse kinds of rule breaking for which society provides no explicit label and which, therefore, sometimes lead to the labeling of the violator as mentally ill"⁷¹

Labeling someone mentally ill also contains a gendered component and the common wisdom is that women are over-represented among mental health patients.⁷² Psychotropic drugs are prescribed for women twice as often as for men, and women are more likely to

65. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, 39 (1999). Similarly, mental illness has been defined as "health conditions characterized by alterations in thinking, mood, or behavior (or some combination) associated with distress and/or impaired functioning." *Facts & Figures About Mental Illness*, available at <http://www.nami.org/fact.htm> (The National Association of Mental Illness website).

66. See, e.g., THOMAS S. SZASZ, THE MANUFACTURE OF MADNESS, A COMPARATIVE STUDY OF THE INQUISITION AND THE MENTAL HEALTH MOVEMENT xxiii (1970); BRANT WENEGRAT, ILLNESS AND POWER 6 (1995) (explaining that some feminists argue that women who challenge social order used to be called witches but today are diagnosed as mentally ill).

67. WENEGRAT, *supra* note 66, at xvi, 23.

68. *Id.* at 23.

69. CAMPBELL & HEGINBOTHAM, *supra* note 58, at 21.

70. JOEL T. BRASLOW, MENTAL ILLS AND BODILY CURES: PSYCHIATRIC TREATMENT IN THE FIRST HALF OF THE TWENTIETH CENTURY 9 (1997).

71. WARREN, *supra* note 57, at 46.

72. BUSFIELD, *supra* note 64, at 2.

have electro-convulsive shock therapy (ECT).⁷³ Moreover, there is a gendered pattern in the diagnosis of mental disorder.⁷⁴ For example, 90% of cases of anorexia nervosa are female.⁷⁵ Women are also more likely to be diagnosed with depression or anxiety than men.⁷⁶ But as one commentator points out, if the boundaries of mental disorder were changed to include violent and criminal activity (including child abuse), alcohol and drug abuse, the gendered patterns of mental illness would change.⁷⁷ Moreover, there is some suggestion that problematic female behavior is viewed as mental illness but problematic male behavior is viewed as wrongdoing.⁷⁸ In other words, diagnosing a person with a mental illness is subjective.⁷⁹

The diagnosis of a physical illness often, although not always, involves a determinative, objective assessment such as a blood test. No analogous procedure is available for mental illness; diagnosis rests on what the patient and others tell the doctor and what the doctor observes.⁸⁰ One writer has noted that “[a]n issue repeatedly raised by feminists within psychology and other mental health fields is the neglect of women’s experiences in the knowledge generated about depression.”⁸¹ Moreover, the majority of the time, the people making the diagnosis of mental illness are “mostly male,

73. *Id.* at 3. Feminist studies have explored the way women are treated in the mental health system, the sexual exploitation of women patients by male therapists, and the use of psychotropic drugs to control female patients. *Id.* at 2–3.

74. *Id.* at 14.

75. *Id.* at 15. In the eighteenth and nineteenth centuries, hysteria was the most widely diagnosed mental disorder among women.

76. The website of NAMI (National Association of Mental Illness) indicates clinical depression affects twice as many women as men and then discusses biological, genetic, psychological and social factors that may lead to this disparity. *Women and Depression*, available at <http://www.nami.org/helpline/women.html> (last visited Sept. 18, 2003) (NAMI is a non profit a group that advocates on behalf of people with severe mental illness). See also RICHARD A. LIPPA, GENDER, NATURE AND NURTURE 27 (2002); Anne Rhodes & Paula Goerings, *Gender Differences in the Use of Outpatient Mental Health Services*, in WOMEN’S MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 21 (Bruce Lobotsky et. al eds., 1998); and Janet M. Stoppard, *Gender, Psychological Factors, and Depression*, in DEPRESSION AND THE SOCIAL ENVIRONMENT: RESEARCH AND INTERVENTION WITH NEGLECTED POPULATIONS, 121 (Philippe Cappeliez & Robert I. Flynn eds., 1993).

77. BUSFIELD, *supra* note 64, at 101.

78. Others would call it clinical judgment. See JANET M. STOPPARD, UNDERSTANDING DEPRESSION, FEMINIST SOCIAL CONSTRUCTIONIST APPROACHES 9 (2000).

79. *Id.*

80. *Id.*

81. *Id.* at 5.

mostly white, mostly wealthy, mostly American psychiatrists.”⁸² This acts to exacerbate the subjectivity inherent in the diagnosis of a mental illness.

Defining mental illness is fraught with difficulties including the fact that it is heavily dependent on context. In addition to the difficulty in defining mental illness, diagnosing mental illness is also problematic, in large part, because of the subjectivity involved. Diagnosis of mental illness rests largely on what the patient reports and a doctor observes. While it may be easy to recognize the patient’s reporting as subjective, the doctor’s observations may also be subjective and skewed by various biases, including gender.

B. The ADA’s Definitions and Its Interpretation

Title I of the Americans with Disabilities Act prohibits employment discrimination on the basis of a disability.⁸³ The ADA defines “disability” as:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment.⁸⁴

Although the ADA does not define impairment, the regulations promulgated by the Equal Employment Opportunity Commission provide that a mental or physical impairment is “[a]ny physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine.”⁸⁵ In addition, these regulations provide that an impairment can also include “[a]ny

82. PAULA J. CAPLAN, *THEY SAY YOU’RE CRAZY: HOW THE WORLD’S MOST POWERFUL PSYCHIATRISTS DECIDE WHO’S NORMAL* 31 (1995).

83. 42 U.S.C. § 12112(a) (1994). Title II of the Act pertains to public services. *Id.* § 12131. Title III prohibits discrimination in places of public accommodations. *Id.* § 12182.

84. *Id.* § 12102(2). This definition was taken, without change, from the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1988). See Drimmer, *supra* note 8, at 1384–85, (tracing the history of this definition of disability); Arlene B. Mayerson, *Restoring Regard for the “Regarded As” Prong: Giving Effect to Congressional Intent*, 42 VILL. L. REV. 587 (1997) (discussing the interpretation of this provision).

85. 29 C.F.R. § 1630.2(h)(1) (2000).

mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities".⁸⁶

Having an impairment within the meaning of the ADA does not mean that the person is disabled; the impairment must also substantially limit a major life activity.⁸⁷ "Substantially limits" means unable to perform a major life activity that an average person can perform, or that a person is significantly restricted in their ability to perform a major life activity.⁸⁸ Major life activities, which are not defined in the ADA but rather in the regulations promulgated by EEOC, include "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."⁸⁹ This list is not exclusive; reproduction, for example, which is not on the list, can be a major life activity.⁹⁰ EEOC's Interpretive Guidance acknowledges that the list is not exhaustive and includes other activities such as "sitting, standing, lifting, [and] reaching."⁹¹ With the exception of learning, and possibly working, all of the activities on this list are far more apparent as physical activities than mental ones.⁹² Noticeably absent are activities that are typically associated with mental illness, such as the ability to get along with others, the ability to have appropriate emotive reactions, or to have ordered cognitive functioning.⁹³ It is not until one reaches EEOC's Enforcement Guidelines⁹⁴ that some of these activities are even mentioned. Thus, the Regulation's list of major life activities reveals the supposition that the activities that are truly major in

86. *Id.* § 1630.2(h)(2).

87. 42 U.S.C. § 12102(2)(A).

88. 29 C.F.R. § 1630.2(j)(1)-(2).

89. 29 C.F.R. § 1630.2(i).

90. *Bragdon v. Abbott*, 524 U.S. 624 (1998) (holding that patient with asymptomatic HIV was disabled because the ability to reproduce and bear children was a major life activity within the meaning of the ADA).

91. ADA Title I EEOC Interpretive Guidance § 1630.2(i). Note that the Interpretive Guidance is not the same as the Regulations Implementing Title I of the ADA.

92. Learning might be associated more with developmental delays and some brain injuries but not necessarily with mental illness. Working presents unique problems and it is unclear if this will be upheld as a major life activity. See *Sutton v. United Airlines*, 527 U.S. 471, 477 (2001) (assuming, without deciding, that working is a major life activity).

93. Richard E. Gardner III, *Mind Over Matter?: The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage*, 49 EMORY L. J. 675, 682 (2002).

94. EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities 4 (1997), available at <http://www.eeoc.gov/docs/psych.html> (on file with the University of Michigan Journal of Law Reform). Note that courts do not afford the same degree of deference to Enforcement Guidelines that they do to Interpretive Regulations. See, e.g., *General Electric v. Gilbert*, 429 U.S. 125 (1976).

one's life are physical as opposed to mental. Moreover, it suggests that Congress, in enacting the ADA, and the EEOC, in enforcing Title I of the ADA, envisioned the disability paradigm as a physical one. Because of this emphasis on the major life activities that are affected by a physical disability, it is not surprising that courts have struggled with the question of what constitutes a major life activity with regard to mental illness. For example, some courts have refused to find that the ability to concentrate is a major life activity.⁹⁵ One plaintiff, diagnosed with major depression,⁹⁶ argued that her illness affected her ability to concentrate, a decidedly mental function, and that the ability to concentrate was a major life activity. Although not disputing the diagnosis of mental illness, the court rejected the idea that the ability to concentrate was, by itself, a major life activity.⁹⁷ Thus, the plaintiff could not establish that she was disabled.

The ADA defines a disability, in part, as a physical or mental impairment that substantially limits one or more major life activities. The ADA does not go further and define either "substantially limits" or "major life activities." While various EEOC regulations do attempt to define these terms, the definitions themselves reveal that the focus of this agency is more on physical illnesses than mental ones.

C. Problems Faced by People with Disabilities Under the ADA

1. Discrimination Against People with a Mental Illness— Discrimination against someone with a mental disability is, in some ways, just like discrimination on the basis of race, gender, or physical disability. Discrimination on the basis of a mental disability, however, has unique aspects. In race or gender discrimination, someone is discriminated against because of membership in a

95. *Pacle v. Kmart Corp.*, 166 F.3d 1300, 1305 (10th Cir. 1999) *cert. denied*, 528 U.S. 811 (1999) (holding that concentration is not a major life activity under the ADA). *See also* *Hook v. Georgia-Gulf Corp.*, 788 So. 2d. 47, 55 (La. Ct. App. 2001) (declining to accept concentration as a major life activity); *Lemire v. Silva*, 104 F. Supp. 2d. 80, 87 (D. Mass. 2000) (holding that the ability to concentrate is not a major life activity); *Philips v. Wal-Mart Stores, Inc.*, 78 F. Supp. 2d. 1274, 1282 (S.D. Ala. 1999) (holding that concentration is not a major life activity); *Henderson v. New York Life, Inc.*, 991 F. Supp. 527, 537 (N.D. Tex. 1997) (concentration is not a major life activity recognized under the ADA).

96. *Pacle*, 166 F.3d at 1300.

97. *Id.* at 1305.

protected class.⁹⁸ An employer may refuse to hire all African-Americans because they are identified as African-American, or all women because they are women. Discrimination on the basis of a physical disability is different; someone is discriminated against because they have a particular physical disability and not necessarily because of their membership in a group of people labeled “disabled.” Those who wear the designation of physically disabled are a very diverse group; an employer may discriminate within that group by refusing to hire someone with AIDS or cancer but hiring someone with diabetes or who is deaf. Although people who are labeled as mentally disabled are also a very diverse group, discrimination on the basis of a mental disability may operate more like discrimination on the basis of race or gender—it may be membership-based because it fails to make nuanced distinctions among the class members. For example, an employer that would not hire someone who is diagnosed with bipolar disorder might be just as likely to refuse to hire someone with a different diagnosis of mental illness.⁹⁹ Thus, people who are mentally ill are subject to the same stereotypes regardless of the degree of severity of their illness,¹⁰⁰ its manageability, its behavioral consequences, or particular diagnosis. Accordingly, once an employer believes that an employee or applicant has a mental illness, the exact nature of that illness may well be irrelevant.¹⁰¹ The failure to differentiate between different types of mental illness may be due to the strength of our reactions to people with mental impairments. In other words, just as in race or gender discrimination, once someone is seen as a member of the group labeled “mentally ill” they are subject to stereotypes and other responses that lead to employment discrimination.¹⁰²

98. They may also be discriminated against based on their perceived membership in a protected class.

99. In *Addington v. Texas*, 441 U.S. 418, 430 (1979), the Court recognized the difficulty for even psychiatrists differentiate behaviors and to render a diagnosis with certainty. See also Eve M. Brank, et al., *Parental Compliance: Its Role In Termination of Parental Rights Cases*, 80 NEB. L. REV. 335, 345 (2001) (noting that the Nebraska statute at issue failed to differentiate between mental retardation and mental illness and thus lumping the two different categories into one); Stefan, *supra* note 9, at 273–74 (noting that the degree of discomfort people feel upon learning that someone is mentally ill is not dependent on the severity of that person’s symptoms).

100. Stefan, *supra* note 9, at 273–74.

101. *APA Fact Sheet*, *supra* note 4.

102. Note that this is different from how we treat persons with physical disabilities. Some physical disabilities affect us differently than others; we may be more uncomfortable

There may also be some difference in how we treat someone with a mental illness, such as obsessive compulsive disorder ("OCD") as opposed to a mental condition, such as mental retardation or a physical condition, such as deafness. Although the ADA's definition of a disability encompasses both physical and mental diseases, such as OCD and cancer and mental or physical conditions such as mental retardation or deafness, diseases and conditions elicit quite different responses.¹⁰³ While both diseases and conditions may be disabling, they are not the same. Our society views both disease and conditions as something that should be cured.¹⁰⁴ Some people¹⁰⁵ who are labeled "disabled," do not want to be "cured" because they believe there is nothing wrong with them.¹⁰⁶ A person who is Deaf may be viewed as disabled, but may need no medical treatment: he or she is not ill. A person with disease, such as skin cancer, may, in fact, require medical intervention, and may or may not be disabled.¹⁰⁷

People who have a mental illness may also be different from people with other kinds of illness because they may reject their label entirely. While a Deaf person may not think of deafness as a disability, he or she would accept the label of non-hearing. A person with a mental illness, however, may entirely reject the concept/label of mental illness.¹⁰⁸

People with a mental illness who accept the label of disability may still feel separate from those with a physical disability. Some advocates of rights for people with mental disabilities suggest that they join forces with the physically disabled as proponents of rights for all kinds of disabilities.¹⁰⁹ This suggestion is based on a view that disability is largely socially constructed.¹¹⁰ But some people with mental disorders do not want to be a part of this model because they perceive that the disability rights movement has traditionally

around someone with a profound visual impairment than we are around someone in a wheelchair.

103. Eichhorn, *supra* note 8, at 1411.

104. BICKENBACH, *supra* note 7, at 64-65 (discussing the medicalization of disability).

105. People who are deaf may not want to have their hearing "corrected." See PAUL C. HIGGINS, MAKING DISABILITY: EXPLORING THE SOCIAL TRANSFORMATION OF HUMAN VARIATION, 237-238 (1992).

106. Eichhorn, *supra* note 8, at 1411.

107. ANITA SILVERS ET AL., DISABILITY, DIFFERENCE, DISCRIMINATION, PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY 77 (1998).

108. STEFAN, *supra* note 16, at 48.

109. WILLIE V. BRYAN, IN SEARCH OF FREEDOM: HOW PERSONS WITH DISABILITIES HAVE BEEN DISENFRANCHISED FROM THE MAINSTREAM OF AMERICAN SOCIETY 30 (1996).

110. *Id.*; BICKENBACH, *supra* note 7, at 135-137; HIGGINS, *supra* note 105, at 25.

excluded people with mental illness.¹¹¹ Accordingly, some people with a mental illness feel that they are discriminated against even within the disability community.¹¹²

Discrimination against people with disabilities takes many forms. Discrimination in the workplace could be a refusal to hire or a termination. Discrimination on the basis of a mental illness, however, has some unique aspects and can include violence *against* someone with a mental disability.¹¹³ It can also have quite subtle effects such as silencing people with mental illness who may refuse to talk about their illness.¹¹⁴ It can also lead to fear that the people in the workplace “won’t go to lunch with you, won’t socialize with you, won’t want to work alongside of you.”¹¹⁵

In many ways, discrimination on the basis of a mental illness is much like any other kind of discrimination. It may, however, be more subject to stereotypes about members of the class of persons with a mental illness than those with a physical illness. Discrimination against someone with a physical disability may well be based on the particular kind of physical disability. Discrimination on the basis of a mental illness, however, may be more group based; if you are mentally ill, the exact nature of your illness may be unimportant because you are clustered with everyone else labeled mentally ill.

2. *Problems Under the ADA*—While some problems encountered under the ADA are unique to people with a mental disability, they also face many of the same problems as people with a physical disability. In numerous disability cases, both mental and physical, employers argued that the condition was not a disability.¹¹⁶ When employers are successful in convincing the court that the plaintiff is not a member of the protected class, the case is dismissed.¹¹⁷ Proving membership in the protected class rarely has been a

111. See BRYAN, *supra* note 109, at 30.

112. SAYCE, *supra* note 5, at 133.

113. *Violence Against Mentally Disabled Poses Dilemma for Families*, CNN.COM, Dec. 18, 2000, at <http://www.cnn.com/2000/HEALTH/12/18/disabled.victims.ap/index.html> (on file with the University of Michigan Journal of Law Reform).

114. See, e.g., Charlotte Huff, *Secret suffering—Fear of stigma can prevent disclosure of illness*, FT. WORTH STAR-TELEGRAM, June 11, 2000 (quoting Peggy Mastroianni, legal counsel, E.E.O.C.).

115. *Id.*

116. Crossley, *supra* note 20, at 623 (noting that this issue is frequently litigated). See also Peter David Blanck & Mollie Weighner Marti, *Attitudes, Behavior and the Employment Provisions of the Americans with Disabilities Act*, 42 VILL. L. REV. 345, 352 (1997) (noting that the definition of disability is one of the “most contentious aspects of disability law”).

117. Crossley, *supra* note 20, at 621.

significant issue in cases of race or sex discrimination brought under Title VII,¹¹⁸ but it is *the* major issue in disability discrimination cases.¹¹⁹ The question whether someone is disabled within the meaning of the ADA has proven to be a major stumbling block for plaintiffs and the vast majority lose on this ground.¹²⁰ The courts' unwillingness or inability to give a broad reading to the term disability is well documented.¹²¹ Many commentators have written criticizing this aspect of the ADA and its interpretation in the courts.¹²² Their suggestions would go far in alleviating the problems encountered in enforcing the ADA, regardless of the type of disability and will not be discussed in detail here. These suggestions would not, however, eliminate the second-class status of mental disabilities in comparison to physical ones.

The courts' reluctance to find that the plaintiff's impairment constitutes a disability within the meaning of the ADA necessarily focuses on whether that impairment "substantially limits a major life activity." The courts' hesitation to find that a plaintiff is disabled is due, at least in part, to stereotypes about disability in general and mental illness in particular. In *Breiland v. Advance Circuits, Inc.*,¹²³ for example, the court considered whether the ability to get along with others was a major life activity. The plaintiff, diagnosed with major depression and schizoid personality disorder,¹²⁴ was disciplined for yelling, in anger, at a co-worker, putting garbage on a table in the lunchroom, using profanity

118. See, e.g., Jane Byeff Korn, *Cancer and the ADA, Rethinking Disability*, 74 S. CAL. L. REV. 399, 414 (2001); Kevin W. Williams, *The Reasonable Accommodation Difference: The Effect of Applying the Burden Shifting Framework Developed Under Title VII in Disparate Treatment Cases to Claims Brought under Title I of the American with Disabilities Act*, 18 BERKELEY J. EMP. & LAB. L. 98, 131 (1997).

119. Colker, *supra* note 20, at 99–100; Crossley, *supra* note 20, at 621; Williams, *supra* note 118, at 131.

120. Colker, *supra* note 20, at 99–100; Korn, *supra* note 118, at 416; S. Elizabeth Wilborn Malloy, *Something Borrowed, Something Blue: Why Disability Law Claims Are Different*, 33 CONN. L. REV. 603, 605 (2001).

121. See, e.g., Samuel Bagenstros, *Subordination, Stigma & "Disability,"* 86 VA. L. REV. 397 (2000); Korn, *supra* note 118.

122. See, e.g., Michelle Friedland, *Not Disabled Enough: The ADA's "Major Life Activity" Definition of Disability*, 52 STAN. L. REV. 171 (1999); Wendy Wilkinson, *Judicially Crafted Barriers to Bringing Suit Under the Americans with Disabilities Act*, 38 S. TEX. L. REV. 907, 910 (1997); Susan M. Gibson, Note, *The Americans with Disabilities Act Protects Individuals with a History of Cancer from Employment Discrimination: Myth or Reality?*, 16 HOFSTRA LAB. & EMP. L.J. 167 (1998).

123. 976 F. Supp. 858 (D. Minn. 1997). *But see* McKenzie v. Dovala, 242 F.3d 967 (10th Cir. 2001) (giving broad interpretation to ADA in case involving mental illness).

124. 976 F. Supp. at 860.

during a confrontation with a supervisor, angry reactions to a supervisor, and excessive use of profanity. The plaintiff was suspended for an "incident of uncontrolled anger and for violation of the offensive behavior policy."¹²⁵ The plaintiff alleged that he was discriminated against because of his mental illness which he argued substantially limited him in the major life activity of getting along with others. The court observed that getting along with others was different from the other kinds of major life activities that were listed in the regulations.¹²⁶ Holding, therefore, that the ability to get along with others was not a major life activity, the court noted its subjective and contextual nature and found that it was "not the sort of activity within" the purview of the ADA.¹²⁷

The emphasis on physical disability, as opposed to mental, is also evidenced in the legislative history. Courts, turning to legislative history in order to discern the meaning of the term "disability," have noted that while it is replete with evidence of discrimination on the basis of physical disability, there are very few references to discrimination on the basis of a mental disability.¹²⁸ Accordingly, while the problems encountered by people with a mental illness are sometimes similar to those faced by people with a physical disability, the ADA poses some unique issues for people with a mental disability. Some of these distinctive issues arise from the focus, by Congress and the EEOC, on the prototype of physical disability.

125. *Id.* at 861.

126. *Id.*

127. *Id.* at 862.

128. Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?*, 8 J.L. & HEALTH 15, 25 (1993/1994) (finding two references); Carolee Kvorciak Lezuch, Note, *The Americans with Disabilities Act: Redefining "Major Life Activity" To Protect the Mentally Disabled*, 44 WAYNE L. REV. 1839, 1843-33 (1999) (finding no mention of discrimination on the basis of mental illness). One commentator has suggested, however, that the direct threat defense was put into the ADA as a defense against hiring people with mental disabilities, and serves to reinforce the stereotype that people with mental disabilities are more likely to pose a threat.

III. STIGMA AND STEREOTYPES

A. *The Stigma of Mental Illness*

People with all types of disabilities are stigmatized.¹²⁹ We use the stigma of disability as a way of separating ourselves from people with disabilities¹³⁰ and mental illness is no exception.¹³¹ People with disabilities are seen with pity and fear,¹³² and as inferior, needy, and dependent.¹³³ While some people who are seen as having overcome a disability may be admired or even viewed as inspirational,¹³⁴ disabilities usually make people uncomfortable.

Stereotypes about people with mental disabilities include that they are "erratic, deviant, morally weak, unattractive, sexually uncontrollable, emotionally unstable, lazy, superstitious, [and] ignorant."¹³⁵ Many believe that if mentally ill people would only try harder, they would get well.¹³⁶ In this view, mental illness is due to internal weakness or other personal shortcomings.

Alternatively, some view mental illness as virtually untreatable.¹³⁷ Mental illness is also seen, by some, as a myth, less real than a physical disorder.¹³⁸ In part, this is because we do not believe what we cannot see. Unlike some physical disabilities, mental illness is not readily observable. When we think of a disability, we usually think of someone who is in a wheelchair or who is blind. We can readily see the assistive devices that some people use, such as a wheelchair or a seeing-eye dog, and those assistive devices have

129. BICKENBACH, *supra* note 7, at 143; Diller, *supra* note 6, at 1003; Adrienne L. Hiegel, Note, *Sexual Exclusions: The Americans with Disabilities Act as a Moral Code*, 94 COLUM. L. REV. 1451 (1994).

130. Korn, *supra* note 118, at 417.

131. See Patrick W. Corrigan et al., *Prejudice, Social Distance, and Familiarity with Mental Illness*, 27 SCHIZOPHRENIA BULL. 219 (2001); Michael L. Perlin, "Where the Winds Hit Heavy on the Borderline": *Mental Disability Law, Theory and Practice*, "Us" and "Them", 31 LOY. L.A. L. REV. 775, 787 (1998).

132. Diller, *supra* note 6, at 1003.

133. BICKENBACH, *supra* note 7.

134. SIMI LINTON, CLAIMING DISABILITY, KNOWLEDGE AND IDENTITY, 17-18 (1990) (arguing that disabilities are not overcome but rather that a person with a disability can only overcome the stigma of being disabled).

135. Perlin, *supra* note 131, at 785.

136. *Id.* at 787.

137. Mental illness is, however, treatable. See, e.g., American Psychiatric Association, *Mental Illness (An Overview)*, available at http://www.psych.org/public_info/overview.cfm (last visited Sept. 18, 2003).

138. Fred Osher, *Mental Illness and Violence*, BALTIMORE SUN, Mar. 24, 2000, at 13A. See also Tom Siegfried & Sue Goetinck, *Mental Illness is No Myth* (1996), available at http://www.pendulum.org/articles/articles_dmn_nomyth.html (last modified Dec. 25, 2002).

become almost synonymous with disability. But many disabilities, both physical and mental, are “invisible.” People with a mental illness do not have assistive devices or readily observable manifestations and, accordingly, just do not fit the traditional image of a person with a disability.

People with mental disabilities may be treated as infants, or alternatively, as demons.¹³⁹ Many are embarrassed by people with mental illness.¹⁴⁰ People who are mentally disabled are also believed to be incapable of being good parents and thus, should not reproduce.¹⁴¹ The stigma of being diagnosed with a mental illness may cause some to forgo treatment, rather than incur the many disadvantages of being labeled “mentally ill.”¹⁴²

While every society seems to have its scapegoats, people with mental illness are disproportionately placed in this role.¹⁴³ People with mental disabilities today may well be “the most despised and feared group in our society.”¹⁴⁴ Part of this fear is the same fear that is commonly felt about physical disability—the able-bodied

139. Perlin, *supra* note 131, at 787.

140. CAMPBELL & HEGINBOTHAM, *supra* note 58, at 20.

141. Susan Kerr, *The Application of the Americans with Disabilities Act to the Termination of the Parental Rights of Individuals with Mental Disabilities*, 16 J. CONTEMP. HEALTH L. & POL'Y 387, 387 (2000). This may be particularly true in some minority cultures. Erica Goode, *Disparities Seen in Mental Care for Minorities*, New York Times, August 27, 2001, at A1. See also *Buck v. Bell*, 274 U.S. 200 (1927) (finding sterilization of mentally disabled was constitutional). Stephen Jay Gould, however, has argued that Carrie Buck was not mentally disabled but rather, was institutionalized as a way to hide a pregnancy. See Stephen Jay Gould, *Carrie Buck's Daughter*, 2 CONST. COMMENT. 331, 336–37 (1985). See also Roberta M. Berry, *From Involuntary Sterilization to Genetic Enhancement: The Unsettled Legacy of Buck v. Bell*, 12 NOTRE DAME J. L. ETHICS & PUB. POL'Y 401 (1998).

142. CAMPBELL & HEGINBOTHAM, *supra* note 58, at 23; Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 8–9 (2000); Hope Yen, *Stigma Remains Barrier for Mentally Ill, Advocates Say*, PITTS. POST-GAZETTE, Mar. 7, 2000, at B8. A person with a physical illness is more likely to seek treatment than someone who has a psychiatric condition. The National Women's Health Information Center, *Women with Disabilities: Psychiatric Disabilities*, available at <http://www.4women.gov/wwd/psychiatric.htm> (last visited Mar. 14, 2002) (on file with the University of Michigan Journal of Law Reform). Moreover, it is possible that the stigma of mental illness has kept us from providing treatment. Nicole Martinson, *Inequality Between Disabilities: The Different Treatment of Mental versus Physical Disabilities in Long-Term Disability Benefit Plans*, 50 BAYLOR L. REV. 361, 361 (1998). It should also be noted that only a small percentage of people with mental illness actually get adequate care and minorities are much less likely than whites to get adequate care. *Few With Mental Illness Get Adequate Care—US Study*, May 10, 2002, available at <http://www.contac.org/contactlibrary/research62.htm> (last visited Sept. 18, 2003).

143. For example, one explanation of the witch trials is that they involved men and women who were undiagnosed as mentally ill. See USSHER, *supra* note 53, at 55.

144. Perlin, *supra* note 17, at 82.

fear that one day they may be physically disabled.¹⁴⁵ Similarly, people may be afraid that they, one day, may become mentally disabled.

People also fear those with mental illness because they associate mental illness with violence.¹⁴⁶ The label mentally ill conjures up images of people who are not competent or safe to be around.¹⁴⁷ The term mentally ill is equated with crazy, meaning out of control and out of touch with reality. The stigma of mental illness may often be harder for patients than the mental illness itself.¹⁴⁸

People who are mentally ill and in the workplace fare no better. Employers fear workplace violence and resulting liability.¹⁴⁹ While violence in the workplace is a problem, it is not caused primarily by people with mental disorders; workplace homicides are principally caused by robbery and are not usually the result of mental illness.¹⁵⁰

The prejudice against people with mental illness has been called sanism and this prejudice is comparable to racism and sexism.¹⁵¹ Sanism is pervasive, and it is perpetuated by judges,¹⁵² by doctors, and by social workers.¹⁵³ Sanism is evident in our language. As one mental health activist explained, "We're not language police. We don't expect the word crazy to disappear. But we're hoping for the day when these stereotypes are as unacceptable as racist and sexist remarks."¹⁵⁴ Oddly, sanism may lessen if mental illness is coupled with a physical one. A recent study has indicated that persons with

145. Eichhorn, *supra* note 8, at 1415.

146. See, e.g., Crossley, *supra* note 20, at 666.

147. CAPLAN, *supra* note 82, at 11.

148. James Willwerth, *It Hurts Like Crazy. (Offensive Portrayals of the Mentally Ill)*, TIME, Feb. 15, 1993, at 53 available at 1993 WL 2931775. This stigma may cause people with a mental illness to fail to seek treatment. A 1999 study done by the Surgeon General of the United States indicates that nearly half of all people in the country with a severe mental illness fail to seek treatment. Press Release, U.S. Dept. of Health and Human Services, "Scientific Revolution" in Mental Health Research and Services Declared in First Surgeon General's Report on Mental Health, available at <http://www.nimh.nih.gov/events/prsurgeon.cfm> (last modified Oct. 4, 2000).

149. Karen Dill Danforth, *Reading Reasonableness out of the ADA: Responding to Threats by Employees with Mental Illness Following Palmer*, 85 Va. L. Rev. 661, 684 (1999). See also McKenzie v. Dovala, 242 F.3d 967 (10th Cir. 2001) (involving plaintiff, with 10 years of experience as a sheriff, who was not hired by any law enforcement agency following treatment for mental illness based, at least in part, on concerns about liability).

150. Danforth, *supra* note 149, at 684. In fact, persons with mental disabilities may be the target of acts of violence. *Supra* note 113.

151. Perlin, *supra* note 131, at 791.

152. See also Perlin, *supra* note 20, at 12.

153. Kerr, *supra* note 27, at 393 (arguing that social workers, along with lawyers, judges and psychologists believe that people with mental disabilities are unable to be adequate parents).

154. Willwerth, *supra* note 148 (quoting remarks of Jean Arnold).

both a mental disability and a physical one do better in the employment arena than those with a mental disability alone.¹⁵⁵ Experts postulate that this may be because the presence of the physical disability reduces the stigma of having a mental illness.¹⁵⁶ After all, if you have cancer, people can understand why you have anxiety or depression. If, however, your life looks good to others, depression or anxiety is not so understandable.

The stigma of mental illness pervades our culture and is perpetuated in the media.¹⁵⁷ More than half of Americans believe that persons with mental illness are more likely to commit acts of violence than those who are not mentally ill.¹⁵⁸ When a crime is committed, newspaper articles frequently cite that the alleged criminal has a history of mental illness.¹⁵⁹ Studies of movies and television programs reveal that "the image of people with mental illness as psychotic killers and 'evil people' has become deeply embedded in our popular culture."¹⁶⁰ The vast majority of portrayals of persons who are mentally ill are as violent and dangerous.¹⁶¹ One study tracked the portrayals of people with mental illness on television in prime time and found that more than 72% of the television characters were portrayed as violent.¹⁶²

To make the problem even more intractable, stereotypes about people with mental illness are contradictory. On the one hand, one common view is that mental illness is a predictor of violence. On the other hand, a different, but also common belief, is that mental illness is made up, and that if the person were only stronger or better, the mental illness would be eliminated.¹⁶³ In fact, the majority

155. BONNIE & MONAHAN, *supra* note 12, at 35.

156. *Id.* (proposing other possible explanations).

157. Douglas Biklen, *The Culture of Policy: Disability Images and Their Analogues in Public Policy*, 15 POL'Y STUD. J. 515 (1987).

158. APA Fact Sheet, *supra* note 4.

159. See generally *supra* note 2.

160. Ken Parish Perkins, *Screen Stigma: Television Depicts Mentally Ill as Drug-Abusing, Law-Breaking Psychos*, CHI. TRIB., Aug. 24, 2000, at 9.

161. *Id.* See also Aaron Barnhart, *Malice in 'Wonderland'*, KAN. CITY STAR, April 5, 2000, at F1; Steven E. Hyler et al., *Homicidal Maniacs and Narcissistic Parasites: Stigmatization of Mentally Ill Persons in the Movies*, 42 HOSP. & COMMUNITY PSYCHIATRY 1044 (Oct. 1991).

162. Willwerth, *supra* note 148, at 53.

163. National Mental Health Association, *Did You Know? NMHA Statistics*, available at <http://www.nmha.org/infoctr/didyou.cfm> (last visited Sept. 18, 2003) (citing statistic that in a recent survey, 71% of the people polled believed that mental illness is caused by emotional weakness and that 43% believed that mental illness is brought on by the individual). See also Susan Brink, *For Severe Mental Illness, A Higher Profile and New Hope*, U.S. NEWS & WORLD REP., Dec. 20, 1999, available at <http://www.usnews.com/usnews/issue/991220/nycu/mental.htm> (on file with the University of Michigan Journal of Law Reform) (noting

of people believe that mental illness is caused by emotional weakness or bad parenting.¹⁶⁴ Many also believe that mental illness is caused by immoral behavior or is otherwise brought on in some way by the individual.¹⁶⁵

Because the stigma associated with being diagnosed with a mental illness is so severe, it may inhibit people from getting treatment. The stereotypes about mental illness reveal that very little is actually known about mental illness. While physical disabilities may make others uncomfortable, mental disabilities often instill fear. It is this fear factor that differentiates the stigma associated with mental disabilities from that of physical disabilities.

B. The Stereotype of Violence

People who are mentally ill are feared primarily because others assume that they are violent or will become violent.¹⁶⁶ This fear is prevalent in the workplace, and may cause much of the employment discrimination against people with mental illness.¹⁶⁷ Although the common perception is that there is a correlation between mental disorder and violence,¹⁶⁸ the question whether such a relationship actually exists is a difficult one to answer.¹⁶⁹ Most of the

that one message of the new issued report by the Surgeon General is that mental illness is as real as heart disease). In fact, one form of mental illness, depression, is now second only to heart disease as the most disabling illness suffered by employees. Australasian Business Intelligence: The Mercury (Dec. 18, 2000) (citing an international labor organization survey).

164. Even judges have these stereotypes. See Perlin, *supra* note 152, at 14–16.

165. National Mental Health Association, *supra* note 163.

166. Bruce G. Link et al., *Public Conceptions of Mental Illness; Labels, Causes, Dangerousness, and Social Distance*, 89 AM. J. OF PUB. HEALTH 1328 (1999). The perception that people with mental illness are violent affects not only our laws about mental illness but also our informal interactions. This fear of violence has been noted since before the Christian era. John Monahan, *Major Mental Disorders and Violence to Others*, in HANDBOOK OF ANTISOCIAL BEHAVIOR 92 (David M. Stoff et al. eds., 1997).

167. John Monahan et al., *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. PSYCHIATRY 312 (2000).

168. The stereotypical image of people with mental illness that is portrayed by the media may be a major factor. Monahan, *supra* note 166, at 92.

169. See, e.g., Jeffrey W. Swanson, *Mental Disorder, Substance Abuse and Community Violence: An Epidemiological Approach*, in VIOLENCE AND MENTAL DISORDER, DEVELOPMENTS IN RISK ASSESSMENT 101, 131–132 (John Monahan & Henry J. Steadman eds., 1994) (“On the one hand, we now have some hard numbers to back up the notion that persons with serious and persistent mental illness are on average more violent than the rest of the population. . . . On the other hand, we now have compelling evidence that the mentally ill, as a group, do not pose a high risk in absolute terms. Only about 7% of all those with major mental disorder (but without substance abuse) engage in any assaultive behavior in a given year.”).

recent studies suggest that while a correlation may exist, it is quite small and/or weak.

1. *Violence in the Workplace*—Some people assert that there has been an increase in violence in the workplace and blame, in part, the ADA.¹⁷⁰ Underlying this position is the assumption that people with mental illness are the ones that cause violence in the workplace,¹⁷¹ that violence is predictable,¹⁷² and that compliance with the ADA makes it impossible to screen out people who are likely to become violent.¹⁷³ All three assumptions are incorrect.

Those who point out that violence in the workplace is increasing frequently cite to statistics that show that violence is the leading cause of death for women in the workplace and the second leading cause of death for men.¹⁷⁴ Another statistic used to support the

170. See Vicki A. Laden & Gregory Schwartz, *Psychiatric Disabilities, the Americans with Disabilities Act the New Workplace Violence Account*, 21 BERKELEY J. EMP. & LAB. L. 246, 270 (2000) ("The new workplace violence account . . . posits that worker-on-worker violence is a serious problem and suggests that potentially violent workers can be identified and removed from the workplace before disaster descends. Furthermore, it portrays the ADA as an unfortunate obstacle around which a prudent employer must navigate to protect employees.").

171. See Jennifer J. Hamilton & Anne N. Walker, *Negligent Hiring and Retention: Walking the ADA Tightrope Between Being Too Careful and Not Careful Enough*, 7 No.5 CONN. EMP. L. LETTER 2 (1999) (finding an "undeniable correlation between acts of workplace violence and certain types of mental illness"); Laden & Schwartz, *supra* note 170, at 251 (describing an individual who among other things, overreacts to perceived injustice, has few friends or apparent interests and seems strange, meeting media stereotype of individual who is likely to "go postal").

172. Ann Hubbard, *The ADA, the Workplace and the Myth of the "Dangerously Mentally Ill"*, 34 U.C. DAVIS L. REV. 849, 852-53 (2001) (discussing current belief that risk of violence is tied to mental illness, but concluding that connections is based on many factors, including age, gender, socioeconomic status and "the presence . . . of hostile or threatening relationships"). But see Kathleen D. Zylan, Comment, *Legislation that Drives Us Crazy: An Overview of "Mental Disability" Under the Americans with Disabilities Act*, 31 CUMB. L. REV. 79, 108 n.198 (2001) (citing Marnie E. Rice & Grant T. Harris, *The Treatment of Mentally Disordered Offenders*, 3 PSYCHOL. POL'Y & L. 131, 133 (1997) (reporting upon a study that suggested that predictions of future violence by psychiatrists and psychologists were wrong for two out of three patients)).

173. See Danforth, *supra* note 149, at 694. ("[R]eading the duty of reasonable accommodation out of the ADA for disabled employees who make threats in the workplace serves to promote the very stereotypes the Act was implemented to overcome."); Georgia A. Staton & Greg J. Thompson, *A Practical Perspective on Employee Violence and the Americans with Disabilities Act*, 35 ARIZ. ATT'Y 32, 32 (1999) (suggesting screening of applicants may protect employers against workplace violence liability but stating that such screening may violate the ADA). But cf. Hubbard, *supra* note 172, at 852-53.

174. See, e.g., Ann Hayes, *Workplace Violence: Prediction and Prevention*, 20 PACE L. REV. 297, 298 (2000); Louis A. Karasik & Nicole Rivas, *Workplace Violence*, NAT'L L.J., April 24, 2000, at B7. There are at least three reasons why women are killed more often than men: 1) women are frequently the first visible employee 2) women are frequently employed in personnel and human resources and 3) domestic violence spills over into the workplace. Karasik *supra*.

claim that violence in the workplace is escalating is the fact that there are more than one thousand homicides in the workplace each year,¹⁷⁵ more than two million people become victims of violence in the workplace each year,¹⁷⁶ 18,000 people are assaulted at work each week,¹⁷⁷ and sixty-one people are injured by acts of violence in the workplace each day.¹⁷⁸ About 20 percent of these violent attacks involve offenders who are armed.¹⁷⁹ The costs of these physical attacks for employers are enormous; one estimate is \$4.2 billion.¹⁸⁰ Some have predicted that as the economy takes a downturn and layoffs increase, acts of violence will increase.¹⁸¹

Other experts, however, dispute that there is an increase in workplace violence.¹⁸² According to these experts, the "one thousand homicides each year" include the deaths of retail store clerks and taxi cab drivers that are killed during armed robberies committed by intruders and customers. Retail employees are the most likely to be murdered while at work.¹⁸³ While we hear a lot about disgruntled employees returning to the workplace armed, in fact, only 7% of workplace homicides are committed by current or former employees.¹⁸⁴ At least two major employers have discovered that workplace homicides can be greatly reduced by preventing robberies.¹⁸⁵ Accordingly, "the problem of workplace violence derives overwhelmingly from companies failing to protect workers from outsider crime."¹⁸⁶ Regardless of the actual statistics, however,

175. K. Tia Burke, *Violence in the Workplace: Why Employers Are Caught In The Middle*, 21 PA. LAW. 18, 18 (1999). From 1990–1994, homicide was the leading cause of on-the-job deaths in California, the District of Columbia, Michigan, and New York. Michael Wiesenfeld, *Death of a Salesman: A True Story About OSHA Recommendations And Workplace Homicide*, 3 U. PA. J. LAB. & EMP. L. 133, 134 (2000).

176. Burke, *supra* note 175, at 18.

177. Kimberly Gee Stith, *Violence in the Workplace: The Armed and Angry Employee*, 29 Brief 8 (Fall, 1999) (citing 1997 statistics from the National Institute for Occupational Safety and Health).

178. Kristine Hayes, *Prepostal Prevention of Workplace Violence: Establishing an Ombuds Program as One Possible Solution*, 14 OHIO ST. J. ON DISP. RESOL. 215, 216 (1998).

179. Gregory M. Posner-Weber, Book Review, 72 WIS. LAW. 50 (May, 1999).

180. Georgia A. Staton & Greg J. Thompson, *A Practical Perspective on Employee Violence and the Americans with Disabilities Act*, 35 ARIZ. ATT'Y 32 (Apr., 1999).

181. Mike France, *The Workplace: Violence*, BUS. WEEK, Mar. 12, 2001, at 98.

182. Laden & Schwartz, *supra* note 170, at 270.

183. Wiesenfeld, *supra* note 175, at 133. (noting that "75% of workplace murders occur during robberies, compared to nine percent of murders being robbery-related in the general population").

184. Laden & Schwartz, *supra* note 170, at 256.

185. *Id.* at 257 (citing the experience of Southland Corporation and Roy Rogers restaurants).

186. *Id.* at 259.

most people believe that an employee with a mental illness is dangerous.¹⁸⁷

2. *Violence and Mental Illness*—While some studies have shown that people with mental illness are no more violent than the general population,¹⁸⁸ other studies indicate that although there is a correlation between violence and mental illness,¹⁸⁹ it is limited.¹⁹⁰ Suffice it to say, not all people who are mentally ill will commit acts of violence.¹⁹¹ Moreover, recent studies indicate that about 90% of those diagnosed as mentally ill are not violent.¹⁹²

Compared to the magnitude of risk associated with the combination of male gender, young age, and lower socioeconomic status for example, the risk of violence presented by mental disorder is modest. Compared to the magnitude of risk associated with alcoholism and other drug abuse, the risk associated with 'major' mental disorders such as schizophrenia and affective disorder is modest indeed. Clearly, mental illness status makes at best a trivial contribution to the overall level of violence in society.¹⁹³

Despite these facts, people associate mental illness with violence and this perception is increasing.¹⁹⁴

While mental illness is one factor that may help predict violent behavior, it is only one of many. For example, anger may be a fac-

187. *Id.* See also William Atkinson, *Workplace Violence*, 2 GLOBAL ENERGY BUS. 48 (Aug. 1, 2000) (noting that "many perpetrators are mentally ill and may be predisposed to violence as a result of their illness"). In fact, however, studies indicate that it is family members, not co-workers, who are most at risk of an act of violence by someone with a mental illness. *APA Fact Sheet*, *supra* note 4.

188. See, e.g., Astrid James, *Foreword* to LANCET, Sept. 26, 1998; Alison Bass, *Stigma Against Mental Illness Persists Despite New Research*, HOUSTON CHRONICLE, Feb. 16, 1992, at A3.

189. Monahan, *supra* note 166, at 97.

190. Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, in *VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT* 137, 156-157 (John Monahan & Henry J. Steadman eds., 1994); SAYCE, *supra* note 5, at 33; Edward P. Mulvey & Jess Fardella, *Are The Mentally Ill Really Violent?*, PSYCHOL. TODAY, Nov./Dec. 2000, at 39, available at 2000 WL 10789899.

191. Mulvey & Fardella, *supra* note 190, at 39.

192. Monahan, *supra* note 166, at 97.

193. *Id.*

194. Fred Osher, *Mental Illness and Violence*, BALT. SUN, March 24, 2000, at 13A (finding that while 13 percent of the public associated violence with mental illness in the 1950s, that figure has increased to 31 percent in the 1990s, at the same time that the "amount of violence attributable to persons with mental disorders decreased").

tor predictive of risk of violence.¹⁹⁵ Other factors include age, gender, marital history, economic status, and education.¹⁹⁶ Experiencing psychotic symptoms may also be a factor in violent behavior.¹⁹⁷ Accordingly, it is not the existence of a diagnosis of mental illness that causes violence. "Relating to persons as if they represent a violence threat simply because of their history of illness or hospitalization represents a grave personal injustice. . . ." ¹⁹⁸

To reach the point where not all people with a mental illness are feared on the grounds that they will become violent, the question becomes whether we can determine *which* people with, or without, a mental illness are likely to become violent. Twenty years ago, the legal question surrounding the prediction of violent behavior was whether it was constitutional and in turn, whether violence could be accurately predicted.¹⁹⁹ After the Supreme Court concluded that it was constitutional,²⁰⁰ this led to the assumption that violence can be accurately predicted.²⁰¹ The most recent technique used for predicting violence has been actuarial methods.²⁰² But in assessing risk of violent behavior, we must also ask what counts as "violence." For example, while assault counts as a violent act, the definition of violent acts could, but does not necessarily include, acts such as vehement gestures, verbal threats, damage to property, and drunk driving.²⁰³

Workplace violence leaves the employer open to liability²⁰⁴ in part because many assume that workplace violence is preventable

195. Raymond W. Novaco, *Anger as a Risk Factor for Violence Among the Mentally Disordered*, in *VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT* 21, 23 (John Monahan & Henry J. Steadman eds., 1994).

196. Jeffrey W. Swanson, *Mental Disorder, Substance Abuse and Community Violence: An Epidemiological Approach*, in *VIOLENCE AND MENTAL DISORDER, DEVELOPMENTS IN RISK ASSESSMENT* 10, 32 (John Monahan & Henry J. Steadman eds., 1994).

197. Link, *supra* note 190.

198. *Id.* at 156.

199. In *Schall v. Martin*, 467 U.S. 253 (1984) and *Barefoot v. Estelle*, 463 U.S. 880 (1983), the United States Supreme Court held that a court may consider evidence regarding the risk that a defendant will remain dangerous. For a discussion of these decisions, see, e.g., John Monahan, *Violence Prediction, The Past Twenty and the Next Twenty Years*, 23 *CRIMINAL JUSTICE AND BEHAVIOR* 107, 108-109.

200. *Schall v. Martin*, 104 S. Ct. 2403 (1984) and *Barefoot v. Estelle*, 463 U.S. 880 (1983).

201. Monahan, *supra* note 199, at 112.

202. Monahan, *supra* note 167, at 312.

203. Douglas Mossman, *Assessing Predictions of Violence: Being Accurate About Accuracy*, 62 *J. CONSULTING & CLINICAL PSYCHOL.* 783, 783 (1994).

204. For a discussion of the various forms of liability faced by an employer, see, e.g., Kristine L. Hayes, *Prepostal Prevention of Workplace Violence: Establishing an Ombuds Program as One Possible Solution*, 14 *OHIO ST. J. ON DISP. RESOL.* 215, 217-226 (1998); Stith, *supra* note 177.

and predictable.²⁰⁵ Thus, an employer who could not predict or prevent workplace violence could be viewed as negligent. Most experts, however, agree that violence can be very difficult to predict,²⁰⁶ and that the people who commit acts of violence may not be the ones we suspected.²⁰⁷ Understanding the difficulty of the task, the American Psychiatric Association stated that "psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, predictions of future violence will be wrong for two out of every three patients."²⁰⁸ Thus, predicting violence accurately is difficult, even for doctors trained in psychiatry. The conditions that are likely to increase the risk of violent behavior in persons with mental illness are the same as those likely to increase the risk for people who are not mentally ill.²⁰⁹

Others, however, assert that violence is predictable and that there are warning signs. In an effort to predict violence among employees, various "profiles" have emerged. The typical profile includes warning signs such as substance abuse,²¹⁰ unwanted romantic interest and/or harassment, extremist opinions or attitudes, and preoccupation with weapons.²¹¹ Many experts advise employers to review their hiring processes to assure that they include thorough background checks, verification of all information, and psychological testing.²¹² Other violence prevention suggestions

205. Romauld A. Stone & Ronda Hayes, *Developing Policies Addressing Workplace Violence*, EMP. RELATIONS TODAY, Sept. 1995, at 25; Anastasis Toufexis, *Workers Who Fight Firing With Fire*, TIME, April 25, 1994, at 34.

206. See, e.g., Susannah Patton, *Looking for Clues on Workplace Violence: Where Next?*, CNN.COM, May 4, 2001, available at <http://www.cnn.com/2001.career/trends/05/01/office.violence.idg>.

207. Mulvey & Fardella, *supra* note 190.

208. APA Fact Sheet, *supra* note 4 (acknowledging that people with neurological impairments and psychoses are at greater risk of becoming violent; note, however, that this does not translate into a prediction).

209. *Id.*

210. Some research suggests that those with less serious forms of mental illness but who do abuse substances are the highest risk for committing acts of violence. Mulvey, & Fardella, *supra* note 190.

211. Hayes, *supra* note 174, at 299. But see *About Mental Illness*, at <http://www.compeer.org/1/a9.asp> (last visited Sept. 18, 2003) (listing ten very different warning signs of mental illness including a marked personality change, the inability to cope with problems and daily activities, thinking or talking about suicide and excessive anger).

212. See, e.g., Karasik & Rivas, *supra* note 174, at B7; Stith, *supra* note 177, at 15.

include establishing handgun policies, disciplinary policies, and updating security measures.²¹³

Some people assert that employees do not suddenly snap out of control but rather give signals that foreshadow the violence.²¹⁴ One editorial suggested that employers conduct psychological testing especially in Internet firms that "often draw talented but antisocial loners."²¹⁵ According to one writer, prospective employees should be asked, in an effort to predict violence, "What did you like most about your last job? Least? At any time, did you think you were being treated unfairly in your last job?"²¹⁶ According to this writer, a belief that one has been treated unfairly is a predictor of violence. A job applicant who had experienced discrimination on a prior job would have difficulty answering these questions. Some people who believe that they have been treated unfairly actually have been and they may, or may not, have a mental illness.

One profile of a violent employee that has emerged is one who is male, white, 35 years old or over with few outside interests, an interest in guns, a tendency to file grievances and complaints, and who has a drug or alcohol abuse problem.²¹⁷ Others suggest, however, that substance abuse is usually not involved and that the most accurate predictors are paranoid, depressed, or suicidal persons who continually file unreasonable complaints.²¹⁸

While many believe that people who have a mental illness are more likely to commit acts of violence, this stereotype does not go in the opposite direction. While an argument could be made that anyone who commits an act of violence other than in self-defense must have some form of mental illness, we have not adopted this viewpoint. Evidence of violent behavior does not automatically connote mental illness, but evidence of mental illness raises fears of violent behavior.²¹⁹

213. See, e.g., Suth, *supra* note 204, at 15; William Atkinson, *The Everyday Face of Workplace Violence*, RISK MANAGEMENT, Feb. 1, 2000, at 12 (suggesting workplace violence insurance); Karasik & Rivas, *supra* note 174, at B7; Kerry Parker, *Workplace Violence Considerations for Employers*, N. J. LAW., Apr. 1999, at 18 (also suggesting employee assistance programs and reserving the right to review employee e-mail).

214. Toufexis, *supra* note 205, at 34.

215. Editorial, *Mass Murder in Wakefield*, PROVIDENCE J., Dec. 28, 2000, at B6.

216. William Atkinson, *Workplace Violence*, GLOBAL ENERGY BUSINESS, Aug. 1, 2000, at 48.

217. Toufexis, *supra* note 205, at 23.

218. *Id.*

219. In *Fenton v. Pritchard Corp.*, 926 F. Supp. 1437 (D. Kan. 1996), the plaintiff tried to argue that the defendant's belief that he was prone to violence indicated that the employer believed that plaintiff was mentally ill. The court rejected this view and noted that even though the defendants admitted that they believed the plaintiff "had a propensity for

V. THE DISABILITY DIVIDE—THE DIVISION BETWEEN PHYSICAL AND MENTAL DISABILITY

When discussing disabilities, people routinely distinguish between mental and physical disabilities. Although this distinction has been around for an extremely long time,²²⁰ it is time to question whether, under the ADA, this distinction is warranted.

The ADA makes three main distinctions between people with physical disabilities and people with mental disabilities. First, the ADA refers to people with a physical *or* mental disability.²²¹ In so doing, the ADA reinforces and perpetuates the idea that physical and mental disabilities are two different states with a clear dividing line. Second, while the ADA does not exclude any specific physical disabilities from coverage, it *does* exclude several conditions that could be classified as mental disabilities including transvestism, pedophilia, exhibitionism, voyeurism, compulsive gambling, kleptomania, and pyromania.²²² Finally, Regulations promulgated pursuant to the ADA contain a list of examples of major life activities. This list includes, for the most part, those kinds of activities that are more likely to be associated with a physical disability than a mental one.²²³

A. Examples of the Dividing Line and the Justifications

In some contexts, there is a need to distinguish exactly what is a person's medical condition or disability. To the extent that we are interested in properly diagnosing and treating a disability, the

violence, . . . that does not ipso facto connote a belief by Pritchard [defendant] that Fenton [plaintiff] was mentally disabled." 926 F. Supp. at 1445.

220. SHORTER, *supra* note 27, at 1.

221. See, e.g., 42 U.S.C. § 12101(a)(1) (1994). The Act also sometimes refers to people collectively as having disabilities without differentiating between physical or mental. See, e.g., *Id.* § 12101(a)(2).

222. 29 C.F.R. § 1630.3(d)(1). Note that many on this list of exclusions would be considered a mental disorder under the Diagnostic and Statistical Manual of Mental Disorders. William M. Tarnow, *Genetic and Mental Disorders Under the ADA*, 2 DEPAUL J. HEALTH CARE L. 291, 310 (1998).

223. See EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities, *supra* note 94.

exact label to place on it may be of importance.²²⁴ But distinguishing a mental illness from a physical illness may make no sense when deciding whether someone is entitled to the protections of the ADA. By making the distinction in the ADA, Congress reinforced the idea that the two should be treated differently and legitimized the division in subtle ways.

This division between disabilities is apparent in a number of contexts. Historically, general physicians treated both mental and physical illness,²²⁵ but today, physical illness is treated by general physicians or specialists in treating specific physical disorders; mental illness is generally treated by psychiatrists. But it seems that the modern difference in who treats mental versus physical illness is not the cause of the dividing line between mental and physical but rather is the effect of the dividing line.

The distinction between physical and mental illness or disorders is deeply entrenched in our legal system and is found in many areas of the law.²²⁶ People with certain mental incapacities are excused from performance in contracts.²²⁷ In criminal law, people who are adjudged "insane" may be found not guilty for that reason.²²⁸ There is no parallel for persons with physical disabilities.²²⁹ On the other hand, people with physical disabilities

224. Labeling in cases of mental illness may do more harm than good. See CAPLAN, *supra* note 82, at 11.

225. SHORTER, *supra* note 27.

226. Richard E. Gardner, III, Comment, *Mind Over Matter?: The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage*, 49 EMORY L.J. 675, 676 (2000) (providing some information regarding mental illness from prehistoric times)

227. See Restatement (Second) of Contracts § 15(1) (1979) (allowing contractual duties to be voided if obligee is unable to reasonably understand or perform contractual obligations due to mental illness of which obligor is aware). See also *Ortelere v. Teachers' Retirement Board*, 303 N.Y.S.2d 362, 368 (N.Y. 1969) (focusing inquiry on whether appellant could understand nature of contract); *Wurst v. Blue River Bank*, 454 N.W.2d 665, 671 (Neb. 1990) (placing burden of asserting lack of mental capacity on party making assertion); *Acosta v. Cole*, 178 So. 2d 456 (La. App. 1965) (finding evidence clearly established plaintiff's mental illness).

228. See, e.g., DANIEL N. ROBINSON, *WILD BEASTS & IDLE HUMOURS: THE INSANITY DEFENSE FROM ANTIQUITY TO THE PRESENT* (1996). The insanity defense has been around for a long time and apparently was present in Ancient Mohammedan law. Michael S. Moore, *Legal Conceptions of Mental Illness*, in *MENTAL ILLNESS: LAW & PUBLIC POLICY* 27 (Baruch Brody & Tristram Engelhardt eds., 1980). Some states have now adopted another variation on the not guilty by reason of insanity and that is guilty but insane.

229. See Restatement (Second) of Contracts § 15(1) (1979) (stating contract duties voidable only if by reason of mental illness or defect, obligee is unable to reasonably understand the nature and consequences of the transaction or is unable to reasonably act in relation to the transaction and obligor knows of his condition). But see Restatement (Second) of Contracts § 208 cmt. d (1981) (stating that factors which may make bargaining process unconscionable include physical infirmity that affects weaker party's ability to protect his interests).

who commit torts may be excused from liability or otherwise accommodated by tort law.²³⁰ They will be compared to a reasonably prudent person with the same physical disability rather than one with no physical disability.²³¹ This permits people with physical disabilities to defend on the grounds that they were unable to "avoid the evil complained of" because of their disability.²³² The courts have repeatedly rejected such a defense in tort law for persons with mental disabilities.²³³ One commentator notes that three reasons have been advanced recently for this difference in treatment:

1. Difficulty in drawing the lines to limit excuse-based psychological problems.
2. Difficulty in ascertaining who is genuinely mentally disabled. This includes concerns that mental illness is easier to fake than physical disability and whether someone's mental problems, even if believed, amount to mental illness.
3. In deciding between two innocent people, the plaintiff and the alleged tortfeasor, the tortfeasor should bear the loss even if he or she is mentally ill.²³⁴

All of these reasons have been criticized and attributed to bias against people with mental disabilities.²³⁵

One of the justifications for the dividing line between physical and mental disabilities is that while physical disability is equated with functional ability,²³⁶ mental disability is associated more with behavior.²³⁷ Employers may believe that providing a reasonable

230. John V. Jacobi, *Fakers, Nuts and Federalism: Common Law in the Shadow of the ADA*, 33 U.C. DAVIS L. REV. 95, 101-02 (1999).

231. *Id.* at 102.

232. Jules Coleman, *Mental Abnormality*, in MENTAL ILLNESS: LAW AND PUBLIC POLICY 113 (Baruch Brody and Tristram Engelhardt eds., 1979).

233. Jacobi, *supra* note 230, at 103-04 (pointing out that physical disabilities are treated differently in tort law than mental disabilities).

234. *Id.* at 107. A fourth reason mentioned in older cases is that imposing liability on people with mental disabilities will encourage their care takers to carefully supervise their activities. *Id.* at 108.

235. *Id.* at 111-113 (arguing that the courts' denial of a defense to tort liability to persons with a mental illness while allowing it for persons with a physical illness is a violation of Title II of the Americans with Disabilities Act).

236. Korn, *supra* note 118 at 447-448 (arguing that physical disability is associated with physical functioning but that this is not really what a disability is about); Danforth, *supra* note 149, at 677.

237. Danforth, *supra* note 149, at 677.

accommodation for a person with a mental disability is, therefore, more problematic.²³⁸ "What are employers expected to do to accommodate alcoholics, the mentally retarded, or persons with neurotic or psychotic disorders? This Senator has no idea and I doubt that other Senators do either."²³⁹ While it is possible to visualize and create what accommodations might be needed for a person with a physical disability, the accommodations necessary for someone with a mental illness are harder to discern.

Just as in accommodating a physical disability, the accommodations for a mental disability might be minimal or might need to be quite extensive. These might include flexible scheduling, private workspace, assigning an understanding supervisor, and allowing an employee to work at her own pace.²⁴⁰ Many accommodations for physical disability are tailored to meet the functional difficulty of the employee, such as the need for a ramp or a reader. Accommodations for a mental illness, however, such as an understanding supervisor, also help people without any disability.²⁴¹ This has led some employers to believe that they will be providing accommodations for people who do not really need them but who would simply like a more understanding supervisor or a more flexible schedule.

The problem of accommodating people with a mental illness in the workplace appears more difficult than accommodating someone with a physical disability and, as a result, many employers refuse to make accommodations for persons who are mentally ill.²⁴² In fact, the question of accommodating someone who may not be able to interact well with others, or who makes sudden emotional outbursts, is accusatory, or who will need to disengage or cease work together during depressive episodes that may be brief or protracted, is perplexing. Yet, it bears noting that accommodations for many physical disabilities seemed just as intractable years ago. Accommodations for physical disability, however, have been made and no longer appear nearly as difficult as they seemed at first.²⁴³

238. *Id.*

239. 135 CONG. REC. 10, 783 (daily ed. Sept. 7, 1989), *quoted in* William M. Tarnow, *Genetic and Mental Disorders Under the ADA*, 2 DEPAUL J. HEALTH CARE L. 291, 292 (1998).

240. Jeffrey I. Cummings & James D. Douglas, *Personnel Update: An Employer's Duty to Accommodate Mental Illness in the Workplace*, SC40 A.L.I.-A.B.A. 263, 273 (1998).

241. BONNIE & MONAHAN, *supra* note 12, at 125.

242. Huff, *supra* note 114 (noting that nearly 40% of human resource managers indicated that they had not made accommodations for persons with mental illness).

243. See, e.g., Nicole Bondi et al., *Denver Disability Advocates Have Refused to be Ignored*, ICAN NEWS SERVICE, June 27, 2000, available at <http://www.ican.com/news/fullpage.cfm?articleid=15830877-380A-426F-84B93A4C3E767DF7> (last visited Sept. 18, 2003)

Similarly, employers may also be concerned that an accommodation of someone's mental illness may cause more work or increased resentment for some other employee. Again, this problem is not unique to accommodating people with mental illness; accommodating people with physical disabilities may also cause work displacement and resentment. Moreover, employers may feel that having to deal with an employee with a mental illness who displays problematic behavior may cause hardship for other employees who work in close proximity and who cannot close their door to get away. But in the not so distant past, employers also worried how their employees would cope with hiring someone with cerebral palsy or who had severe scarring from burns and yet, employers and employees have survived and adjusted. The difference appears to be that employers have gotten somewhat comfortable with accommodating physical disabilities but there is a long way to go regarding mental disabilities.²⁴⁴ Finally, just as with physical disabilities, employers must recognize that not all employees with a disability need an accommodation. Moreover, it is only after an employee gets past the significant hurdle of establishing that they have a disability within the meaning of the ADA that the employer is required to attempt to make a reasonable accommodation.²⁴⁵ Finally, not all accommodations need to be made; some are unreasonable and would cause an undue hardship.

Employers also worry that if they make accommodations for someone who is mentally ill, they will have to make similar accommodation for the "office jerk."²⁴⁶ Under the current statutory scheme, however, this "office jerk" would first have to establish that he was, in fact, disabled before an employer would even reach the question of providing an accommodation. Moreover, the question whether someone really needs an accommodation or is somehow faking it, is not unique to mental disabilities; it is also present in physical ones. Just because, for example, an employer accommodates someone with disabling rheumatoid arthritis, this does not mean that it necessarily has to accommodate someone

(discussing tactics used by disability advocates to convince the Denver bus system to accommodate physically disabled riders so that today, only buses with wheelchair lifts are purchased).

244. Miller, *supra* note 9, at 736 (noting that employers have difficulty conceptualizing accommodations for psychiatric disabilities).

245. 29 C.F.R. § 1630.2(o)(1).

246. Sarah Starnes, *Psychiatric Disabilities & the ADA: An Analysis of Conventional Defenses and EEOC Guidelines*, 18 REV. LITIG. 181, 197 (1999).

who pretends to have a back problem. Similarly, just because an employer accommodates someone with severe depression by, for example, allowing time off, it does not mean that the “office jerk” must be similarly accommodated.²⁴⁷

Another offered justification for the dividing line is that we can see when someone has a physical disability but we cannot see a mental illness. This justification, however, ignores the fact that many physical conditions, such as cancer and AIDS, are not readily observable, although their effects may be. Some posit that mental illness is easier to fake than physical illness and this may be true.²⁴⁸ But this argument does not take into account the fact that there are some physical disabilities that can also be feigned.²⁴⁹ It may also be unlikely, due to the associated stigma, that people will even try to feign a mental illness.²⁵⁰ Even if, however, we believe that more people pretend to have mental illness than physical illness, this does not justify stereotyping the entire group as unworthy of belief based on the few that do manage to feign mental illness.

247. Not all the law that has developed surrounding accommodating physical disabilities will work for accommodating mental ones. At least one commentator has suggested that physical and mental disabilities should be treated differently because the concepts developed in cases involving a physical disability do not readily translate into a case involving a mental disability. Kathleen D. Zylan, Comment, *Legislation that Drives Us Crazy: An Overview of “Mental Disability” Under the Americans with Disabilities Act*, 31 CUMB. L. REV. 79, 119 (2000–2001). See also BICKENBACH, *supra* note 7, at 18 (acknowledging that while discussions should apply equally to physical and mental disabilities, his book would not because “because there does seem to be a difference between the two that should make a difference in what a social commitment to equality requires”). This begs the question, however, whether there is any difference to justify a statutory distinction.

248. See Press Release, Office of New York State Attorney General Eliot Spitzer, *Spitzer Announces 36 Charged With Stealing \$1.3 Million in Federal-State Disability Payments*, (April 26, 2001) available at http://www.oag.state.ny.us/press/2001/apr/apr27b_01.html (last visited Sept. 18, 2003) (alleging that 36 people had been charged with faking disorders, including mental illness and retardation). But see Martin Humphreys & Alan Olgilvie, *Feigned Psychosis Revisited—A 20 year follow up of 10 patients*, 20 PSYCHIATRIC BULL. 666 (1996) (finding that all 10 patients who had been previously identified as simulating psychosis were found, 20 years later, to have had a major psychotic illness at some point). The authors of this study suggest that more research in this area should be done to find out why some patients are believed but others are not.

249. See, e.g., Steven I. Freidland, *Law, Science and Malingering*, 30 ARIZ. ST. L.J. 337, 343 (1998).

250. Richard Philip, *Army Craze*, EZYHEALTH, Oct. 18, 2002, available at http://www.southwestcdc.org.sg/article_youth_sep_01.html (last visited Sept. 18, 2003) (on file with the University of Michigan Journal of Law Reform).

*B. Is There Really a Difference Between
Mental and Physical Illness?*

1. *The Biologically-Based View of Mental Illness*—Recently, questions have been raised about whether there should even be a line between mental and physical illness. Historically, those treating mental illness have seen a relationship between the body and mental illness.²⁵¹ This relationship is revealed in a number of ways including the use of malarial fever therapy as a treatment for some forms of mental illness²⁵² as well as convulsive therapies such as electroshock.²⁵³ In later years, the treatment went from treating the body as a whole²⁵⁴ to treating the brain as the center of mental disease.²⁵⁵ Moreover, while for several decades during the first half of the twentieth century, Freud and his theories regarding psychoanalysis were mainstream psychiatry, today there is increasing support for the position that mental illness is biologically based²⁵⁶ “An array of medical studies and analyses of the brain have established that serious mental illnesses are treatable diseases of the brain. Recent findings and research have further substantiated the neurobiological bases for serious mental illness.”²⁵⁷ A “growing body of research” has revealed that mental illness can be treated successfully, and that the “division of the diseases into medical and mental types becomes more arbitrary with every new study.”²⁵⁸ This mounting evidence of a biological base for mental illness blurs the

251. BRASLOW, *supra* note 70, at 2.

252. *Id.* at 71–94 (detailing the development of malaria fever therapy as a treatment for paresis, a tertiary form of syphilis that may cause paralysis).

253. Shock therapies included insulin, metrazol and electric shock. BRASLOW, *supra* note 70, at 96. Moreover, we know today that physical trauma can create some forms of mental illness, such as post traumatic stress disorder following a physical assault. *Id.*

254. USSHER, *supra* note 53, at 106.

255. BRASLOW, *supra* note 70, at 3. *See also* USSHER, *supra* note 53, at 67.

256. BRASLOW, *supra* note 70, at 4. *See also* The Mental Health Equitable Treatment Act of 2001 (stating that severe mental illness is biologically based); United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, <http://www.mentalhealth.org/publications/allpubs/SMA01-3537/chapter1.asp> (arguing that this century will find the genes responsible for biologically based mental illness).

257. Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 65 (1997) (footnotes omitted).

258. *Id.* *See also* DANA CROWLEY JACK, SILENCING THE SELF: WOMEN AND DEPRESSION 2 (1991).

line between physical and mental illness.²⁵⁹ Moreover, as one scientist testified to Congress: "I can state without reservation that research shows no biomedical justification for differentiating serious mental illness from other serious and potentially chronic disorders of the nervous system such as stroke, brain tumor or paralysis."²⁶⁰

One of the benefits of viewing mental illness as biologically based is that it becomes a medical problem, thus making a mentally ill person relatively free of blame for the condition.²⁶¹ A biological base for mental illness eases suspicion that a person diagnosed with a mental illness is either faking it or could cure herself if she would only try harder.²⁶² Most people do not, for example, believe that someone with cancer is either faking it or could cure herself if she tried hard enough.

Finding mental illness to be biologically based, however, will only reduce part of the stigma associated with mental illness;²⁶³ it would not eradicate all of the stigma because people with physical disabilities are also stigmatized.²⁶⁴ It also would not necessarily reduce the stereotype about mental illness and violence.

Although positing that mental illness is biologically based has scientific backing,²⁶⁵ it does have negative ramifications. Among other things, it medicalizes mental illness. The medicalization of mental illness, called by one commentator as the move from

259. Maria Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8 (2000).

260. *Hearing Before the Subcomm. On Labor, Health & Human Serv., Educ. & Related Agencies of the House Comm. on Appropriations*, 104th Cong. 363 (1996) (statement of Stephen Hyman, Director, Nat'l Inst. of Mental Health, Dep't of Health & Human Serv.), *quoted in* Shannon, *supra* note 258, at 67.

261. Morrison, *supra* note 259, at 9 (arguing that many people believe that persons with mental illness are responsible for their own conditions). A recent survey found the following: 71% of the population believed that mental illness was caused by emotional weakness, 65% believed that bad parenting causes mental illness and 45% believed that victims of mental illness could will it away. *Id.* at 9.

262. SAYCE, *supra* note 5, at 87 (noting that blaming the brain reduces the stigma of mental illness).

263. See, e.g., ELLIOTT S. VALENSTEIN, *BLAMING THE BRAIN: THE TRUTH ABOUT DRUGS AND MENTAL HEALTH*, 219 (1998).

264. See Crossley, *supra* note 20, at 666 (arguing that physical disabilities are stigmatized because of personal appearance issues) (note that such an argument only applies to visible physical disabilities and not to hidden ones such as cancer); Linda D. Martin, Note, *Affirmative Action in University of California Admissions: An Examination of the Constitutionality of Resolution SP-1*, 19 WHITTIER L. REV. 373, 410 (1997) (suggesting that physical disabilities carry the danger of stigmatic harm because the presence of disability creates societal and personal doubts as to potential for success). See also Drimmer, *supra* note 8.

265. But see VALENSTEIN, *supra*, note 263, at 3 (disputing that there is strong, scientific evidence for the blame the brain theory of mental illness).

"madness" to mental illness, may suggest a change in who treats people with mental illness.²⁶⁶ The medical model of mental illness cedes to medical doctors the sole power to treat mental illness.²⁶⁷ One of the problems with having only psychiatrists treat mental illness is the political nature of categories. Critics of the medical model of mental illness also point out that sexual orientation used to be viewed as a mental disorder until pressure within the American Psychiatric Association omitted it from the DSM in 1980.²⁶⁸ In order to point out the subjectivity of this decision, one critic commented "Wouldn[']t [sic] it be nice if we could rally and lobby to get the medical profession to take a vote and eliminate cancer as a deadly disease."²⁶⁹ This same critic has pointed out that the DSM used to identify 100 mental disorders and now has certified hundreds more.²⁷⁰

Treating mental illness with drugs has resulted in great advances in treatment, but drugs may also quiet and control the person who takes them and maintain the power of doctors, the only people who can dispense them.²⁷¹ "In answer to the question 'Why do psychiatrists insist that depression is a physical illness?' one answer is "[m]oney, prestige and power."²⁷² It is important to note, however, that at least some of the critics of the biological base theory (or "blame the brain" theory) are not medical doctors.²⁷³ If mental illness is caused by a chemical imbalance treated by medication, only medical doctors can write the prescriptions. Those who treat the illness through measures other than drugs, such as social workers, psychologists and other non-physician mental health therapists, could be out of a job.

An additional problem with the medical model is that it places the problem within the individual's body and negates the

266. CAMPBELL & HEGENBOTHAM, *supra* note 58, at 22 (arguing that this has led to the dominance of traditional medicine in the management of services for people with mental illness).

267. Marilyn La Court, *Mental Illness, A Powerful and Dangerous Idea*, 5-4 PERSPECTIVES, 2000, available at http://www.mentalhelp.net/poc/view_index.php/idx/23/articles (last visited Sept. 18, 2003).

268. *Id.*

269. *Id.* For those who would argue with this criticism on the grounds that cancer can be fatal, it should be noted that mental illness can also be fatal.

270. *Id.* Others point out that the DSM used to identify 60 mental disorders in 1952, while the 1994 version lists 410. Sharon Begley, *Is Everybody Crazy?*, NEWSWEEK, Jan. 26, 1998, at 50.

271. VALENSTEIN, *supra* note 263, at 165.

272. USSHER, *supra* note 53, at 153.

273. La Court, *supra* note 267.

possibility that poverty, war, abuse, neglect,²⁷⁴ or other social phenomena are causative factors. Thus, the medical model may distract attention away from the social factors that shape who becomes mentally ill, and why. In other words, the medicalization of mental illness turns social problems into illness.²⁷⁵ Moreover, if a chemical imbalance causes mental illness, it puts the cure entirely within a patient's and her doctor's control and absolves the rest of society from any responsibility for mental illness.²⁷⁶

Critics of the biological cause approach are worried that if the dividing line between physical illness and biologically-based mental illness is eliminated, those with mental disorders that are not biologically caused or that have an unknown cause²⁷⁷ will become the new second class citizens.²⁷⁸ For example, New Jersey has a mental health parity law which requires parity in insurance between "biologically-based mental illness under the same terms and conditions as provided for any other sickness. . . ."²⁷⁹ Under this law, a biologically-based mental illness is defined as a "mental or nervous condition that is caused by a biological disorder" and includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism."²⁸⁰ While this includes numerous categories, it leaves out many more such as anorexia nervosa and generalized anxiety disorder. Finally, there is some dispute whether a biologically based view of mental illness will reduce discrimination; if genetics can predict who will be born with mental illness then people bearing those genes may be encouraged to not reproduce.²⁸¹

Critics also challenge whether there truly is a causal relationship between chemical imbalance and mental illness. While the proponents of the blame the brain theory argue that a chemical imbalance causes the mental illness, skeptics question whether the

274. *Id.* See also SAYCE, *supra* note 5, at 91.

275. BICKENBACH, *supra*, note 7, at 64 (noting that treating mental or physical illness as a medical problem ignores the possibility that they may caused be social issues).

276. BONNIE & MONAHAN, *supra* note 155, at 113.

277. See, e.g., BRUCE J. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW 100 (1997).

278. SAYCE, *supra* note 5, at 89.

279. NJ Division of Insurance, Bulletin No. 01-06, available at http://www.naic.org.nj.bl01_06.htm.

280. *Id.*

281. SAYCE, *supra* note 5, at 90.

mental illness caused the chemical imbalance.²⁸² Others suggest that it is drug companies who have the most to gain by the acceptance of the idea that mental illness is caused by a chemical imbalance, curable by medication.²⁸³ Moreover, if mental illness is truly caused by a chemical imbalance, it is difficult to explain the research that indicates that psychotherapy alone is just as effective as drugs in treating some disorders such as anxiety and depression.²⁸⁴

I do not mean to suggest that mental illness is not biologically based or that we should not pursue this avenue of research. I do mean to suggest that even if mental illness is found to be biologically based because of a chemical imbalance, for example, this will not resolve all of the problems for people who have a mental illness. It will reduce the stigma and self blame. It may make it easier to ask for treatment. It may end some discrimination against people with some forms of mental illness.

The blame the brain theory is currently popular. In a few years, another theory about the cause of mental illness may develop or a new treatment may be announced. Medical science has used a variety of treatments, now discarded. "But what are we to make of the fact that doctors will use a remedy effectively for many years, and then, sometimes quite suddenly, that remedy becomes transformed, by a strange alchemy, into the therapeutic equivalent of fools' gold?"²⁸⁵

Regardless of the cause of mental illness, and whether we will eventually discover that it is no different from physical illness, the fact remains that we do distinguish between them today. The ADA distinguishes between them, the regulations distinguish between them, and people feel quite differently about them.

282. *Id.*; VALENSTEIN, *supra* note 263.

283. *See, e.g.*, VALENSTEIN, *supra* note 263, at 165.

284. La Court, *supra* note 267 (citing a study posted by the Institute for the Study of Therapeutic Change); VALENSTEIN, *supra* note 263, at 214.

285. BRASLOW, *supra* note 70, at 5.

C. Concrete Ramifications of the Disability Divide—Why the Disability Divide Matters

About 28 percent of the adult population in this country has a diagnosable mental or addictive disorder.²⁸⁶ Mental illness touches every segment of society; it affects men and women, children and senior citizens,²⁸⁷ although not necessarily in the same way. The dividing line between mental and physical illness has subtle effects such as skepticism about whether the person is really mentally ill, and the belief that because the illness is mental, a person could cure herself if she would only try harder. But the dividing line also has very direct and insidious effects on many people who are mentally ill.

1. *The Disability Divide and Insurance*—One concrete ramification of the disability divide is the lack of parity in insurance benefits. For example, Kenneth Hess was hired by Allstate Insurance Company in 1992. As a new employee, Mr. Hess selected a long-term disability plan through Metropolitan Life Insurance Company. A few years later, Mr. Hess became disabled and was unable to work. He was eventually diagnosed with bipolar disorder and his condition was characterized as a mental illness. Accordingly, Mr. Hess' disability benefits were limited to 24 months pursuant to the terms of his policy; had his illness been characterized as a physical illness, the disability payments would not have been subject to this limitation.²⁸⁸ Mr. Hess sued, arguing that the distinction between mental and physical disabilities was discrimination under the ADA. The court ruled that it was not.²⁸⁹ Accordingly, insurance companies learned that despite the enactment of the ADA, it was legitimate to treat mental illness differently from physical illness, at least in terms of long-term disability benefits.

Much has been written about the problem of the disparity of long term disability benefits and whether this should be considered

286. Laura J. Milazzo-Sayre et al., *Serious and Severe Mental Illness and Work: What Do We Know?*, in *MENTAL DISORDER, WORK DISABILITY AND THE LAW* 15 (Richard J. Bonnie & John Monahan eds., 1997).

287. Nicole Martinson, *Inequality Between Disabilities: The Different Treatment of Mental Versus Physical Disabilities in Long-Term Disability Benefit Plans*, 50 *BAYLOR L. REV.* 361, 362 (1998).

288. *Hess v. Allstate Insurance Co.*, 2000 WL 1186262 (D. Me. 2000). *See also* *Dames v. Paul Revere Life Insurance Co.*, 2001 WL 528107 (9th Cir. 2001) (challenging designation of her disability as a mental one as opposed to a physical disability).

289. *Hess*, *supra* note 288, at *10.

discrimination under the ADA.²⁹⁰ The arguments in favor of maintaining the disparity center around cost issues.²⁹¹ Because insurers make calculations based on risk, by declining to cover those at high risk of costly illness, or declining to cover costly conditions or covering them to a lesser extent than other conditions, insurers reduce their costs. According to this argument, by reducing the high costs caused by covering mental illness, the insurer is better able to cover other conditions, such as physical illness.²⁹² One study indicated “that psychological factors such as stress and depression may have a greater impact on health-care costs than physical factors like obesity, smoking and hypertension.”²⁹³ In addition, some commentators have argued for the disparity in benefits on “moral hazard” terms.²⁹⁴ Viewed this way, if insurers cover or increase coverage for mental illness, people will increase their demand for covered services although they would not choose such services if

290. See, e.g., Befort, *Mental Illness and Long-Term Disability Plans Under the Americans with Disabilities Act*, 2 U. PA. J. LAB. & EMP. L. 287 (1999); Stephen F. Douglas A. Blair, *Employees Suffering from Bipolar Disorder or Clinical Depression: Fighting an Uphill Battle for Protection Under Title I of the Americans with Disabilities Act*, 29 SETON HALL L. REV. 1347 (1999); Nancy Lee Firak, *Threshold Barriers to Title I and Title III of the Americans with Disabilities Act: Discrimination Against Mental Illness in Long-Term Disability Benefits*, 12 J.L. & HEALTH 205 (1997-98); Christopher Aaron Jones, *Legislative ‘Subterfuge’?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 VAND. L. REV. 753 (1997); Nicole Martinson, *Inequality Between Disabilities: The Different Treatment of Mental Versus Physical Disabilities in Long-Term Disability Benefit Plans*, 50 BAYLOR L. REV. 333 (1998); Morrison, *supra* note 259; Shannon, *supra* note 258; Andrea K. Short, *Eradicating Discrimination Among Individuals with Disabilities: Parity in Employer-Provided, Long-Term Disability Benefit Plans*, 56 WASH. & LEE L. REV. 1341 (1999); Luke A. Sobota, *Does Title III of the Americans with Disabilities Act Regulate Insurance?* 66 U. CHI. L. REV. 243 (1999).

291. See, e.g., Befort, *supra* note 290, at 287; Maggie D. Gold, *Must Insurers Treat All Illnesses Equally? Mental vs. Physical Illness: Congressional and Administrative Failure to End Limitations to and Exclusions From Coverage for Mental Illness in Employer-Provided Health Benefits Under the Mental Health Parity Act and the Americans with Disabilities Act*, 4 CONN. INS. L. J. 767 (1997-98); Shannon, *supra* note 258, at 70. One recent study indicated that parity would cost just one percent or \$1.32 per employee, according to a Pricewaterhouse Coopers’ analysis of the proposed Mental Health Equitable Treatment Act of 2001. APA Online, *Mental Health Parity Coverage to Cost \$1.32 Per Month*, available at <http://www.apa.org/practice/paritycoverage.html> (last visited Sept. 18, 2003). Others disagree, however, with this and argue that mental health parity would drive insurance costs up by five to ten percent. See National Center For Policy Analysis, *Do We Need More Mental Health Parity?*, June 30, 1999, available at <http://www.NCPA.org.ba.ba297.html>. See also Allison C. Blakley, *Is Depression Disabling America’s Group Insurance Plans? Mental Health Benefit Parity and the ADA*, 27 BRIEF 40, 41 (Sum., 1998) (arguing that higher costs are associated with mental illness than for physical illness).

292. Befort, *supra* note 290; Gold, *supra* note 291, at 771.

293. *Mental-Health Parity or Parody*, *supra* note 3, at 20.

294. Befort, *supra* note 290, at 290.

they were not covered.²⁹⁵ Others put the argument in terms of “adverse selection.”²⁹⁶ In other words, if insurers include coverage for mental health, costs will increase to the point that coverage for other conditions will decrease and/or premiums for everyone will increase.²⁹⁷ Finally, some justify the distinction in coverage between mental and physical illness based on a distrust of mental illness and mental health treatment.²⁹⁸ Mental illness is viewed as more subjective than physical illness and mental health treatment is viewed as less effective than treatment for physical illness.²⁹⁹

Those in favor of parity between treatment of mental and physical illness argue that most of the arguments against parity are based on outmoded views, stigma, and unwarranted suspicion of mental illness.³⁰⁰ Although parity proponents admit that including equal coverage of mental illness will increase costs, they argue that the exact amount of the increase is unknown.³⁰¹ “[O]ne supporter of parity concluded that ‘[t]he only distinction at this point seems to be between one group of insureds whose illnesses manifest themselves in socially stigmatized ways and another group of insureds whose illnesses are more acceptable as physical injury or disease.’”³⁰² Other arguments in favor of parity include that it will actually reduce the number of people disabled by mental illness because it would make mental health treatment more accessible and it would also increase the productivity of and quality of life for those with mental illness.³⁰³

2. *Using the ADA to Legitimate the Disability Division*—Appellate courts have uniformly agreed that the disparity between the benefits recoverable by persons with physical disabilities versus mental disabilities is not discrimination under the ADA.³⁰⁴ The

295. *Id.*; Gold, *supra* note 291, at 771.

296. Gold, *supra* note 291, at 771.

297. Befort, *supra* note 290.

298. See, e.g., Befort, *supra* note 290, at 288; Gold, *supra* note 291, at 774.

299. Befort, *supra* note 290, at 290.

300. *Id.*

301. *Id.*; Gold, *supra* note 291, at 774.

302. Befort, *supra* note 290, at 291.

303. AARP Research, *Mental Health Parity: An Overview of Recent Legislation*, available at http://www.research.aarp.org/health/fs69_mental.html (last visited Sept. 18, 2003).

304. See, e.g., *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144 (2d Cir. 2000); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000); *Kimber v. Thiokol Corp.*, 196 F.3d 1092 (10th Cir. 1999); *Lewis v. Kmart*, 180 F.3d 166 (4th Cir. 1999), *cert. denied* 528 U.S. 1136 (2000) *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), *cert. Denied*, 525 U.S. 1093 (1999); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997); *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039 (7th Cir. 1996). *But see Johnson v. Kmart Corp.*, 273 F.3d 1035, *rehearing en banc granted, vacated* (Dec. 19, 2000). Further decision was stayed pending the

main reason given is that the ADA prohibits discrimination between the non-disabled and the disabled but does not prohibit discrimination between different types of disabilities.³⁰⁵ In essence, this means that one disability is fungible for another. This would be similar to arguing that Title VII prohibits discrimination between a minority and a white person but does not prohibit discrimination between different protected groups. According to this reasoning, it would be lawful under Title VII to discriminate against an African-American in hiring if the successful applicant was a Latino.

In *EEOC v. Staten Island Savings Bank*, for example, the Second Circuit addressed the question whether long term disability policies offered by employers, which provided for benefits for a physical disability until retirement age but only provided for eighteen to twenty-four months of benefits for people with a mental illness, violated the ADA.³⁰⁶ The court found that the language of the ADA was ambiguous as to whether this was allowable.³⁰⁷ According to the court, both plans were facially discriminatory but the court went on to weigh this against the fact that the employees “enjoyed access to exactly the same benefit plans as did their physically disabled and non disabled coworkers.”³⁰⁸ Therefore, according to the court, it could not resolve the question by looking only at the plain language of the statute.³⁰⁹ In holding that these plans did not violate the ADA, the Second Circuit noted that the ADA did not “specifically condemn the historic and nearly universal practice inherent in the insurance industry of providing different benefits for different disabilities.”³¹⁰ Finding that the practice was discriminatory would also “require far-reaching changes in the way the insurance industry does business.” Although the court recognized that Congress could mandate such a change in business practice,

bankruptcy proceedings recently filed by Kmart. 281___ F.3d 1368___, 2002 WL 225679 (11th Cir. 2002).

305. See, e.g., *EEOC v. Staten Island*, 207 F.3d at 144. See also *Disabilities Act: Mental, Physical Disability Distinctions in Long-Term Benefits Plan are Legal*, 66 DAILY LABOR REP. (BNA), April 5, 2000, at A-7.

306. *Staten Island Sav. Bank*, 207 F.3d at 144, was actually a combination of two cases. In one of the cases, the plan provided for benefits for physical illness until retirement age but for only two years for mental illness. In the other case, the plan provided benefits for physical illness until age 65 but provided for only 18 months of benefits for mental illness.

307. *Id.* at 148.

308. *Id.* at 149.

309. *Id.* at 148.

310. *Id.* at 149.

the court was "reluctant to infer such a mandate for radical change absent a clearer legislative command."³¹¹

This reasoning is far from satisfactory. First, it is reminiscent of *General Electric vs. Gilbert*³¹² in which the Supreme Court held that discrimination on the basis of pregnancy was not sex discrimination within the meaning of Title VII. The Court reasoned that the world was, in essence, divided between pregnant and non-pregnant people. Although recognizing that only women could become pregnant, the Court noted that because the non-pregnant group included both men and women, discrimination on the basis of pregnancy was not unlawful sex discrimination. Congress corrected this problematic interpretation by amending Title VII to make clear that pregnancy discrimination was a prohibited form of sex discrimination.³¹³

Moreover, the court's opinion in *EEOC v. Staten Island Savings Bank*³¹⁴ legitimated the standard practice in the insurance industry without a second thought. Although not aimed at the insurance industry, the ADA was enacted for the purpose of "elimination of discrimination against individuals with disabilities."³¹⁵ Given Congress' strong statement of purpose, the court should have looked at whether this insurance practice was contributing to discrimination against people with disabilities before approving of a practice just because it has always been done this way.

Disparity in benefits in long-term disability plans between physical and mental disability, however, is not the only direct disparity facing people who are mentally ill. In 1996, in order to eliminate some of the disparities in benefits received by persons with a mental versus a physical illness, Congress enacted The Mental Health Parity Act³¹⁶ but the particular issue regarding long-term disability

311. *Id.*

312. 429 U.S. 125 (1976).

313. Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (Oct. 31, 1978) (codified as amended in scattered sections of 42 U.S.C. 2000(e)).

314. 207 F.3d 144.

315. 42 U.S.C. § 12101(b)(1).

316. See Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a and 42 U.S.C. § 300gg-5 (Supp. II 1996)). About 18 states have also legislated parity for mental health care. "State-level parity laws have typically eliminated differences in deductibles, coinsurance, and copayments, or limits on the numbers of inpatient days or outpatient visits." Sharon Bee & Mary Jo Gibson, *Mental Health Parity: An Overview of Recent Legislation*, (1998), available at http://www.research.aarp.org/health/fs69_mental.html (last visited Sept. 18, 2003). Other states have pending legislation. *Id.* The recent drive in Congress to eliminate still existing disparities in insurance died in December, 2002. Robert Pear, *Drive for More Mental Health Coverage Fails in Congress*, N.Y. TIMES, December 19, 2001, at A20. This legislation, the Mental Health Equitable Treatment Act of 2001, would have provided full

plans was not addressed. It did, however, address concerns about disparity in health insurance that typically does not cover mental illness to the extent that it covers physical illness.³¹⁷ Although the Mental Health Parity Act ("MHPA")³¹⁸ requires employers who included mental health coverage in their health insurance to cover it to the same extent as physical illness with respect to annual and life-time benefits, the effect of the MHPA has been limited.³¹⁹ First, employers are exempt if compliance would increase their health insurance expenses by more than 1 percent.³²⁰ Second, while annual and life-time benefits are covered by the Mental Health Parity Act, the number of inpatient or outpatient care days is not.³²¹ The employer is still free to offer mental health services with a higher co-payment than that required for health services for physical illness.³²² In addition, the MHPA covers only those employers with fifty or more employees. Finally, many employers just violate the law; those that are technically in compliance with the Act's requirements have found ways to evade the Act's intent to achieve parity.³²³

Some experts question whether the limitations of the Mental Health Parity Act are really a problem. According to a recent study, the vast majority of employers offer some mental health

parity, would have repealed the 1% cost provision and reduced the small business exemption to companies with 25 or fewer employees. *Domenici and Wellstone Introduce New Mental Health Parity Bill*, available at http://www.mhanj.org/Advocacy/parity_bill.htm (last visited Sept. 18, 2003).

317. See, e.g., Brink, *supra* note 163.

318. This Act was passed in 1996 and became effective in 1998. 29 U.S.C. § 1185(a) (2003).

319. See, e.g., Press Release, Russ Newman, Executive Director for Professional Practice, American Psychological Association, Regarding the Mental Health Equitable Treatment Act (April 14, 1999) (on file with the University of Michigan Journal of Law Reform).

320. 29 U.S.C. § 1185a(c)(2). See also *Do We Need Mental Health Parity?*, Idea House, National Center for Policy Analysis, available at <http://www.ncpa.org/ba/ba297.html> (last visited Sept. 18, 2003) [hereinafter *Mental Health Parity*].

321. For example, "Group Health Inc. . . . provides coverage to New York City municipal workers. The HMO replaced its \$900 annual and \$1,800 lifetime outpatient mental health caps with 30- and 60-visit limits annually and for life, respectively." This was called a "serious disservice to policemen, firefighters and others with high-stress jobs who may well need greater levels of care for serious mental illnesses." David L. Coleman, *Mental Health Parity: A Year Later, Are We There?*, MANAGED CARE MAG., January 1999, available at <http://www.managedcaremag.com/archives/9901/9901.parity.html> (last visited Sept. 18, 2003).

322. *Mental Health Parity*, *supra* note 320. See also Coleman, *supra* note 321.

323. Robert Pear, *Many Employers Found to Violate Law Requiring Parity for Mental Health Coverage*, N.Y. TIMES, May 18, 2000, at A26.

coverage.³²⁴ On the other hand, however, the mental health coverage offered is often far less extensive than coverage for physical illness.³²⁵ As with long-term disability plans, many of the arguments surrounding the question of parity in health insurance center around cost. There is no agreement, however, on what parity in health insurance would cost. Estimates range from a cost of less than 1% to a 10% increase.³²⁶ Reluctance to require parity also stems from concerns about fraud. "Medicare administrator Nancy-Ann Deparle contended . . . that 90 percent of the patients had no mental illness serious enough to qualify for special treatment. "You walk into these places and people are playing bingo and eating lunch. . . ." ³²⁷ This comment reveals an underlying assumption that people with physical illness who do require special treatment, would not sit at a facility and eat lunch and play bingo while waiting for treatment if these services were offered. Finally, one argument also offered against parity in health insurance is that while we know when a bone is healed, it is harder to tell when a mind is healed.³²⁸ Based on this argument, however, we could refuse to offer parity in health insurance for cancer because it may also be difficult to tell if a cancer survivor has been "cured."³²⁹

While it is true that some improvement is better than none, and the law may increase public awareness of mental health insurance issues,³³⁰ the failure of the Mental Health Parity Act to actually require parity reinforces stereotypes about mental illness, particularly those about the possibility of fraud and abuse. It also serves to reinforce the idea that health insurance for mental illness is more costly. While there is not much federal data on this question, state data from those states that require parity provides some basis for

324.

91 percent of small firms (10–499 employees) and 99 percent of large firms offer mental health and substance abuse coverage in their most used medical plans.

Mental health and substance abuse coverage was included in 87 percent of indemnity plans, 88 percent of HMOs, 97 percent of Point of Service (POS) plans and 93 percent of Preferred Provider Organizations (PPOs)."

Mental Health Parity, *supra* note 320.

325. *Id.*

326. *Id.*

327. *Id.*

328. *Id.*

329. Korn, *supra* note 118, at 435.

330. Coleman, *supra* note 321.

comparison. Maryland, for example, has a mental health parity law and it resulted in premium increases of less than 1 percent at the end of the first year.³³¹ Finally, the mere existence of a statute entitled the Mental Health Parity Act may lead some into thinking that the MHPA does achieve parity when, in fact, it does not. Thus, some people may be lulled thinking that parity has actually been reached.

3. *EEOC's Role in The Disability Divide*—The Equal Employment Opportunity Commission has also played a role in the disparate treatment of mental and physical disabilities under the ADA. The EEOC agrees with the Court of Appeals that insurance plans that treat mental and physical health differently do not violate the ADA. While some argue that the ADA works out a compromise between the practice of insurance companies and disabled persons, others have been more skeptical.³³²

Section 501(c) of the ADA,³³³ the “safe harbor” provision, provides that insurers may underwrite, classify and administer risks “as long as they are consistent with state law” and are not a “subterfuge to evade the purposes” of the ADA.³³⁴ “The legislative history supports this facial interpretation, noting that insurers may limit insurance coverage based on ‘classification of risks’ creating limitations and exclusions based on an individual’s disability when such practice is ‘based on sound actuarial principles or is related to actual or reasonably anticipated experience.’”³³⁵ According to the EEOC, in order to establish that an insurance plan violates the ADA, a plaintiff must first establish that the insurance plan uses a disability-based distinction. If plaintiff can establish this, the defendant must then demonstrate that its disability-based distinction falls within the safe harbor provision of the ADA.

EEOC makes clear, however, that not all distinctions violate the ADA; it must be a “disability based” distinction. According to EEOC Guidelines, a “term or provision is ‘disability based’ if it singles out a

331. Coleman, *supra* note 321. See also Jessica Luna, *Mental Health Parity: Legislating Equality in Health Insurance Coverage*, at <http://www.law.uh.edu/healthlawperspectives/Mental/010829Mental.html> (last visited Sept. 12, 2003).

332. Compare Christopher Aaron Jones, *Legislative “Subterfuge”? Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 VAND. L. REV. 753, 784 (1997) with Mary T. Giliberti, *The Application of the ADA to Distinctions Based on Mental Disability in Employer-Provided Health and Long-Term Disability Insurance Plans*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 600, 601–602 (1994).

333. 42 U.S.C. § 12201(c).

334. Gold, *supra* note 291, at 791.

335. *Id.*

particular disability (e.g., deafness, AIDS, schizophrenia), a discrete group of disabilities (e.g., cancers, muscular dystrophies, kidney disease), or disability in general (e.g., non coverage of all conditions that substantially limit a major life activity).³³⁶ “Insurance distinctions that are not based on disability, that are applied equally to all employees, do not discriminate on the basis of disability and so do not violate the ADA.”³³⁷ One of the examples of a distinction that is not disability-based is that between physical and mental disabilities. According to the EEOC, this is not disability-based because it applies to the treatment of many dissimilar conditions and has an equal effect on people with and without disabilities.³³⁸ As one commentator has noted, the problem with this position is that physical conditions also affect people with and without them.³³⁹ Moreover, many physical disabilities are quite dissimilar.³⁴⁰

Under this interpretation of the ADA, plaintiffs cannot challenge the disparity in health insurance between mental and physical conditions to even reach the question whether such a distinction is a subterfuge because they can never get past the first requirement, that the distinction be disability-based.³⁴¹ In adopting this interpretation, the EEOC lost focus of one of the overarching lessons of civil rights laws—that the focus is supposed to be on the reason for the defendant’s actions “rather than on comparisons between the plaintiff and some other person or group.”³⁴²

EEOC’s position that distinguishing between mental and physical illness is not a “disability-based distinction” perpetuates stereotypes about people with mental illness by the very agency enforcing the statute that was enacted to eliminate such stereotypes. The EEOC’s position carries great weight—if the EEOC is behind

336. U.S. Equal Employment Opportunity Comm’n, *Application of the Americans with Disabilities Act of 1990 to Disability-Based Distinctions in Employer Provided Health Insurance*, 109 DAILY LABOR REP. (BNA), June 9, 1993, at E-3.

337. *Id.* at D-22.

338. Moreover, according to the EEOC, although such a distinction may have a disparate impact on people with mental disabilities, disparate impact claims are not cognizable under section 501(c). *Id.* Others have criticized this interpretation. See, e.g., Gold, *supra* note 291, at 798–801; Giliberti, *supra* note 332, at 601.

339. Gold, *supra* note 291, at 802–803.

340. *Id.*

341. Note that even if the plaintiff could establish a disability based distinction, it does not necessarily follow that she is entitled to parity. The defendant could, for example, pursuant to the “safe harbor” provision establish that its disparate insurance plan was justified by actuarial risk assessment.

342. Susan Stefan, *The Americans with Disabilities Act and Mental Health Law: Issues for the Twenty-First Century*, 10 J. CONTEMP. LEGAL ISSUES 131, 178 (1999) (making the point that the ADA does not allow discrimination between people with different disabilities).

it, most would think that it must not be discriminatory. Because it is typically mental illness that gets less coverage, it reinforces, in subtle ways, the notion that treatment for mental illness is somehow less real, less deserving and less effective than treatment for physical ailments. People with mental illness, even if they could prove that their illness was caused by an organic change in their brain chemistry, could not challenge a distinction in health coverage.³⁴³ If a person with a mental illness needed the same medication as a person with a physical illness, the mentally ill person can be denied coverage but the person with the physical illness cannot.³⁴⁴ This consequence may feel a lot like being written off, being of no importance. Because it comes from the EEOC, it legitimates the marginalization of people with mental illness.

The position taken by the EEOC, that distinctions by insurance companies between mental and physical illness do not violate the ADA, also has a more concrete result. Insurance companies are encouraged to classify an illness as mental and insureds are forced to litigate whether their particular disability is physical or mental.³⁴⁵ Moreover, rather than focusing on whether a person has been discriminated against on the basis of a disability, our legal system is spending a lot of time, money, and energy arguing about what constitutes a mental, as opposed to a physical, illness.

4. *The Disability Divide—Categorization of Illness as Mental or Physical*—Outside the ADA context, courts have used three methods for determining whether the plaintiff's condition should be categorized as a mental or physical illness for purposes of receiving insurance benefits, typically health or disability.³⁴⁶ The plaintiffs in numerous cases had insurance plans that provided more limited coverage for mental illness than for physical illness.³⁴⁷ Rather than

343. They could, however, challenge the characterization of their illness as a mental one.

344. Giliberti, *supra* note 332, at 603.

345. See, e.g., *Fitts v. Fed. Nat. Mortgage Ass'n*, 236 F.3d 1 (D.C. Cir. 2001) (holding that because disparity in long term disability plan did not violate the ADA but remanded on claim alleging violation of ERISA when disability insurance carrier classified bipolar disorder as a mental disability instead of as a physical disability).

346. See, e.g., *Fitts v. Fed. Nat. Mortgage Ass'n*, 191 F. Supp. 2d 67, 73 (D.D.C. 2002), *opinion withdrawn*, 2002 WL 32123844 (D.D.C.).

347. For example, disability plans typically limit coverage for mental illness to twenty-four months while coverage for physical illness is not so limited. See, e.g., *Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979, 981 (5th Cir. 1996) (containing 24 month limitation on long term mental illness disabilities unless the insured was hospitalized at the end of the 24 month period). In those cases involving health insurance plans, coverage was also more limited for mental than for physical illness. See, e.g., *Heaton v. State Health Benefits*

alleging that this difference in coverage violated the ADA, which would have resulted in a loss for plaintiffs given current case law, the plaintiffs challenged the insurers' categorization of their condition as a mental, as opposed to a physical illness.

In addressing whether an illness is properly characterized as mental or physical, some courts have adopted what has been called the "symptom" or "manifestation approach."³⁴⁸ Under this view, a condition would be classified as a mental illness if its "primary observable symptoms are behavioral."³⁴⁹ In *Brewer v. Lincoln National Life Insurance Co.*,³⁵⁰ for example, the plaintiff had severe affective mood disorder. Rather than looking at how an expert would classify this illness, the court preferred to see how a layperson would think of or define a mental illness. The court noted that non-experts rely on symptoms to classify illness. "[I]llnesses whose primary symptoms are depression, mood swings and unusual behavior are commonly characterized as mental illnesses regardless of their cause."³⁵¹ Accordingly, because a lay-person would have thought of the plaintiff's mood swings as a symptom of a mental illness, the insurance company rightly characterized it as a mental illness, subject to the benefit limitations.³⁵²

Other courts, however, have looked at the cause of the condition in order to determine whether the plaintiff has a mental or physical condition.³⁵³ The insured in *Heaton v. State Health Benefits Commission*³⁵⁴ was diagnosed with Alzheimer's disease. The parties did not "dispute that Alzheimer's is a physical condition, organic and not functional in nature. . . ."³⁵⁵ The insured was hospitalized in a psychiatric hospital and the insurer, therefore, focused on the treatment and argued that this hospitalization was subject to the limitations in coverage for mental illness. Although the court noted that the symptoms of Alzheimer's were behavioral issues, it rejected this approach to characterize Alzheimer's and looked to

Comm'n, 624 A.2d 69, 71 (N.J. Ct. App. 1993) (policy contained a provision limiting lifetime major medical expenses to \$1 million for lifetime but limited coverage for mental illness to an \$10,000 per year and \$20,000 lifetime).

348. Youndy C. Cook, Comment, *Messing With Our Minds: The Mental Illness Limitation in Health Insurance*, 50 U. MIAMI L. REV. 345, 348 (1996).

349. *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991).

350. 921 F.2d 150 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991).

351. *Id.* at 153.

352. *Id.*

353. *See, e.g., Heaton vs. State Health Benefits Commission*, 264 N.J. Super. 141, 624 A.2d 69 (N.J. Ct. App. 1993).

354. 264 N.J. Super. 141 (N.J. Ct. App. 1993).

355. *Id.* at 146.

the etiology (cause) instead. Because the parties agreed that Alzheimer's had an organic (physical) as opposed to a functional (psychological or environmental) cause, it would be considered a physical illness.³⁵⁶

Finally, in a few cases, treatment is what serves as the dividing line between physical and mental illness.³⁵⁷ In *Simons v. Blue Cross & Blue Shield*,³⁵⁸ the patient was diagnosed with anorexia nervosa.³⁵⁹ She was hospitalized for treatment of malnutrition resulting from the anorexia.³⁶⁰ The insurer categorized this as a mental illness, subject to the plan's limitation.³⁶¹ The plaintiff, however, argued that because treatment during this hospitalization was physical in nature, the mental illness limitations did not apply.³⁶² The court, looking to the ordinary understanding of psychiatric treatment, found that it meant things such as "electroshock therapy and psychotropic medication."³⁶³ The court found that the plaintiff, however, had received customary medical treatment for malnutrition.³⁶⁴ According to the court, the treatment for malnutrition was the same regardless whether the cause of the malnutrition was anorexia, some organic source, or poverty.³⁶⁵ Thus, based on the treatment, the court held that the insured's hospitalization was not within the limitations applicable to mental illness.³⁶⁶

Each of these methods has benefits and each has limitations. The symptoms method, which looks to opinions held by lay people over the opinions of experts, may be relying on the population more likely to be affected by stereotypes about mental illness. Moreover, just because a lay person thinks that a certain symptom means that a person has cancer, for example, this does not mean that the person does have cancer. On the other hand, it has some

356. The court went on to find that the policy was ambiguous in that it did not make clear whether the limitations on mental illness pertained to all mental illness or only those that did not have an organic etiology. *Id.* at 150.

357. See, e.g., *Simons v. Blue Cross & Blue Shield*, 144 A.D. 2d 28 (1989).

358. *Id.*

359. The National Eating Disorders Association defines anorexia nervosa as a "serious, potentially life-threatening eating disorder characterized by self starvation and excessive weight loss." National Eating Disorders Ass'n, *Eating Disorders Information Index*, available at http://www.nationaleatingdisorders.org/p.asp?WebPage_ID=294 (last visited Sept. 18, 2003).

360. 144 A.D.2d at 29.

361. *Id.*

362. *Id.* at 32.

363. *Id.* at 28.

364. *Id.*

365. *Id.*

366. *Id.* at 34.

ease of application in that we generally think we know what are the observable manifestations of disease. It may also make some sense when a court is trying to interpret what an insurance plan means by a mental illness to resort to what the ordinary person would think when she read the policy rather than using expert opinion after the fact.

The treatment method seems, in many ways, to be circular. We already know that mental illness is treated by psychiatrists and that physical illness is treated by other doctors. But how do doctors decide who should treat whom? If a person arrives in an emergency room, how is the choice made as to what specialty of physician to call? Imagine that the woman presenting in the emergency room is three days post-partum, feeling hostile to her new baby, like jumping out of her skin, and itchy. This woman, on arriving, had been banging her head against the wall and then pacing like a caged tiger.³⁶⁷ Should the emergency room personnel call her obstetrician, a psychiatrist, an allergist, and/or an endocrinologist? It seems odd to use the form of treatment to define a mental versus a physical illness without also examining what led to that decision.

This problem may have led some courts to adopt the cause or etiology approach which may ease some of the stigma associated with some forms of mental illness. For example, if a disease is organic in origin, it eliminates the guilt of the patient as in "if only I was a better person I wouldn't feel this way." It may also relieve blame placed on others as in "you caused my problems." The etiology approach lets the world know that the patient would not get better if only she would try harder and it indicates that this particular mental illness is just as deserving of treatment as any physical illness. On the other hand, because there are many mental illnesses for which we do not yet know the cause, the stereotypes and stigma associated with those diseases of unknown origin could increase. Moreover, we often do not look at the causes for most physical illness in order to assess blame. For example, we typically do not blame or stigmatize someone who had an accident that led to his paraplegia so we should not stigmatize someone who had an accident that led to organic brain syndrome. This means that we should also not stigmatize someone who has, for example, bipolar disorder or who has survived an abusive childhood.

367. The facts are taken from *Blake v. Unionmutual Stock Life Ins., Co.*, 906 F.2d 1525, 1527 (11th Cir. 1990), in which the plaintiff was diagnosed with postpartum depression and was subsequently hospitalized for an extended period of time.

These three approaches show the way courts have tried to draw the dividing line between physical and mental illness in cases not brought under the ADA. In the context of insurance coverage, much is to be gained by the insured by being categorized as having a physical instead of a mental illness. When bringing a claim under the ADA, however, it is unclear whether anything is gained, by either side, when the employee is categorized as having a physical as opposed to a mental illness. Studies indicate that the vast majority of plaintiffs lose their cases brought under the ADA.³⁶⁸

D. More Subtle Ramifications of the Disability Divide

1. Defining Mental Disability—As in cases involving a physical disability, the courts have struggled with the question whether a particular mental impairment constitutes a disability within the meaning of the ADA.³⁶⁹ Part of the difficulty stems from discerning what is a major life activity. Major life activities include “caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”³⁷⁰ Many activities, however, are not on this list of examples provided in the regulations. For example, courts have had to address whether the ability to get along with others constitutes a major life activity.³⁷¹

The problem for people with a mental illness in establishing that they are disabled within the meaning of the ADA is exacerbated by the vision of a “disability” that is held by those who enforce the ADA, that a disability is an observable, physical limitation. The major life activities that are specified in EEOC’s Regulations all share

368. See, e.g., Ruth Colker, *Winning and Losing Under the Americans with Disabilities Act*, 62 OHIO ST. L.J. 239, 240 (2001) (conducting empirical study of ADA cases on appeal) and Colker, *supra* note 20, at 100 (empirical study concluding that plaintiffs usually lose in ADA cases.). These studies do not, however, differentiate between the success rates based on whether the disability was physical or mental.

369. See, e.g., *Furnish v. SVI Systems, Inc.*, 270 F.3d 445 (7th Cir. 2001); *EEOC v. Woodbridge Corp.*, 263 F.3d 812 (8th Cir. 2001); *Thornton v. McClatchy Newspapers, Inc.*, 261 F.3d 789 (9th Cir. 2001); and *Chenoweth v. Hillsborough County*, 250 F.3d 1328 (11th Cir. 2001).

370. 29 C.F.R. § 1630.2(i) (2002).

371. Compare *Jacques v. DiMarzio, Inc.*, 200 F. Supp. 2d 151, 160 (EDNY 2002) (inability to get along with others is a major life activity) with *Soileau v. Guilford of Maine, Inc.*, 105 F.3d 12, 15 (1st Cir. 1997) (ability to get along with others is not a major life activity).

a common trait; with the notable exception of learning,³⁷² (and possibly working) they are all physical activities. If mental illness is manifested mostly by behavior, then this list of activities, which is not exclusive,³⁷³ fails to mention any of those behaviors that are typically associated with mental illness such as ability to concentrate or to have an appropriate emotional response.³⁷⁴ The EEOC's vision of a disability as primarily a physical one carries over to the courts.³⁷⁵ For example, the EEOC regulations do not include the ability to get along with others as a major life activity.³⁷⁶ As a result, some courts have rejected the argument that the ability to get along with others is a major life activity.³⁷⁷ According to one court, the ability to get along with others "is not the sort of activity within the ADA's purview of a major life activity."³⁷⁸ Another court explained that while the ability to get along with others "is a skill to be prized, it is different in kind from breathing and walking, two exemplars which are used in the regulations."³⁷⁹ The courts' failure to recognize the ability to get along with others as a major life activity demonstrates the vision of a disability in the ADA is of a physical one. Moreover, even if the court would find that the ability to get along with others is a major life activity, the plaintiff must also establish that this activity is substantially limited. This puts the plaintiff in a catch-22. If the plaintiff is substantially limited in the ability to get along with others, i.e., can get along with no one, the plaintiff may then be unable to establish that he or she is otherwise qualified as required by the statute.³⁸⁰

372. Learning might be associated more with developmental delays and some brain injuries but not necessarily with mental illness. Working presents unique problems and it is unclear if this will be upheld as a major life activity. See *Sutton v. United Airlines*, 527 U.S. 471, 477 (2001) (assuming, without deciding, that working is a major life activity).

373. *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998) (holding, on facts of case, reproduction is a major life activity).

374. In *Reeves v. Johnson Controls World Servs.*, 140 F.3d 144, 151 (2nd Cir. 1998), the court noted that major life activities must concern an activity that was significant and not something that was merely trivial. Accordingly, the court rejected the plaintiff's argument that his panic disorder affected the major life activity of everyday mobility.

375. See, e.g., 976 F. Supp. at 863.

376. EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities 4 (1997), available at <http://www.eeoc.gov/docs/psych.html> (last visited Sept. 18, 2003), does mention the ability to get along with others as a major life activities. Note, however, that courts do not afford the same degree of deference to Enforcement Guidelines that they do to Interpretive Regulations. See, e.g., *Gen. Elec. v. Gilbert*, 429 U.S. 125, 141 (1976).

377. See, e.g., *Breiland v. Advance Circuits, Inc.*, 976 F. Supp. 858, 863 (D. Minn. 1997).

378. *Id.*

379. *Soileau v. Guilford*, 105 F.3d 12, 15 (1st Cir. 1997).

380. See, e.g., *Breiland*, 976 F. Supp. at 865.

The courts' inability to envision a disability as other than physical has also arisen in other contexts. A former employee, diagnosed with panic disorder and agoraphobia, alleged that he was discriminated against on the basis of his disability.³⁸¹ According to the terminated employee, because of his agoraphobia, his mobility was limited.³⁸² Given the ADA's emphasis on a major life activity relying on physical function, this was a reasonable argument for the plaintiff. The court, however, rejected his argument, finding that this was not the kind of mobility that could constitute a major life activity within the meaning of the ADA.³⁸³ Although the plaintiff's panic attacks prevented him from doing routine things such as going to a shopping mall, the court noted that the plaintiff's impairment did not prevent the plaintiff from doing major life activities such as walking or working.³⁸⁴ "Plaintiff does not, for example, claim that he was so immobile as a result of his mental impairment that he was unable to leave his house or to go to work."³⁸⁵ It is ironic that if the plaintiff had been unable to leave his house or to go to work because of his mental illness, it is likely that he would be unable to perform the essential functions of the job, and, accordingly, would not be an otherwise qualified individual.³⁸⁶

Thus, the courts have struggled to define a mental disability under the ADA. This is due, in large part, to the stereotypes surrounding mental illness. In addition, however, both the EEOC and the courts appear to have an image of a disability as a physical one. Accordingly, the courts are unable to envision that there are other kinds of disabilities that are not mentioned in the regulations or the Act and therefore mental disabilities are discounted.

2. *The Behavior Conundrum or Misconduct at Work*—One of the ways to distinguish between mental and physical illness is the notion that physical illness is characterized by organic causes and symptoms while mental illness is manifested by behavior.³⁸⁷ In attempting to deal with these manifestations of behavior, courts have become mired in conceptual difficulties. This dilemma becomes

381. *Reeves v. Johnson Controls World Servs., Inc.*, 140 F.3d 144, 148 (2nd Cir. 1998).

382. *Id.* at 148.

383. *Id.* at 150.

384. *Id.*

385. *Id.* at 153.

386. *See, e.g., Niese v. Gen. Elec. Appliances*, 2000 WL 1617774 (S.D. Ind. 2000) (holding that ability to be present at work is an essential function of the job).

387. *See Miller, supra* note 9, at 741 (noting that psychiatric disabilities are associated with behavior).

evident in cases raising the question of what to do with employees who engage in inappropriate conduct in the workplace when that misconduct is allegedly caused by a mental disability.³⁸⁸ This issue arises when, for example, an employee uses profanity in the workplace or is abusive to others,³⁸⁹ is insubordinate or disruptive,³⁹⁰ or makes off-color jokes and sexual comments.³⁹¹ The ADA is, in general, silent on the question of workplace misconduct except for one provision that provides that a person who is abusing drugs or who is an alcoholic may be held to the same standards as other employees "even if any unsatisfactory performance or behavior is related to the alcoholism or drug use of such employee."³⁹² Some courts have held that all persons, even those not abusing drugs or alcohol, can be held to the same standard of performance even when the misconduct is caused by a mental illness.³⁹³ If behavior is at the crux of the distinction between mental and physical illness, then such a position totally eviscerates the ADA with regard to mental illness. In other words, it is one thing to conclude that under the ADA, it is lawful to distinguish between mental and physical disabilities. It is quite another, however, to say that those people with behavioral manifestations of mental illness must act the same as those people who do not have a mental illness. This would be like saying that although you cannot discriminate against a person who is vision impaired, you can hold them to the same standard of vision as everyone else.

This is not to suggest that employers are unable to terminate someone who makes threats in the workplace or engages in other inappropriate behavior. If a person is making threats in the workplace, an employer can utilize the "direct threat" provision

388. The EEOC takes the position that conduct rules in the workplace are appropriate if they are job related and consistent with business necessity. An example includes a librarian who frequently loses her temper at work and disrupts the quiet atmosphere. *Disabilities Discrimination: Commission Counsel Calls EEOC Guidance On Psychiatric Disabilities 'Enlightened' Start*, 47 DLR C-1, March 11, 1998.

389. See, e.g., *Boldini v. Postmaster General*, 928 F. Supp. 125, 128 (D. N.H. 1995) (brought under the Rehabilitation Act of 1973).

390. *Sullivan v. River Valley Sch. Dist.*, 20 F. Supp. 2d 1120 (W.D. Mich. 1998)

391. *Maes v. Henderson*, 33 F. Supp. 2d 1281, 1283 (D. Nev. 1999) (Rehabilitation Act of 1973 claim).

392. 42 U.S.C. § 12114(c)(4) (1994).

393. See, e.g., *Palmer v. Cook County*, 117 F.3d 351 (7th Cir. 1997); *Harris v. Polk County, Iowa*, 103 F.3d 696 (8th Cir. 1996); *Maes*, 33 F. Supp. 1281; *Sullivan*, 20 F. Supp. 2d 1120; and *Boldini*, 928 F. Supp. 125 (D. N.H. 1995). But see *Den Hartog v. Wasatch Acad.*, 129 F.3d 1076 (10th Cir. 1997). See also Jeffrey I. Cummings & James D. Douglas, *Personnel Update: An Employer's Duty To Accommodate Mental Illness In The Workplace*, SC40 A.L.I.-A.B.I. 263, 270 (1998).

and take action against an employee who poses a direct threat to others.³⁹⁴ Moreover, the employer could also take the position that accommodating this particular misconduct presents an undue hardship.³⁹⁵ But holding all people with mental illness to the same standard of behavior as persons without such an illness ignores the fact that mental illness is manifested by behavior. We might not say that a person was mentally ill without such behavior. This raises the question whether only some forms of mental illness are protected by the ADA, perhaps only those that do not make others feel uncomfortable because of behavioral issues or those in which people keep their misery to themselves.

For example, James Newberry was a tenured professor of photography at East Texas State University who was discharged. He alleged that he was discriminated against on the basis of his disability, obsessive compulsive disorder.³⁹⁶ According to the plaintiff he "had difficulty cleaning himself, waking up, sleeping, scheduling his daily routine and controlling his bowel function."³⁹⁷ The disorder, he testified, also interfered with his relations with others by instilling in him excessive perfectionism, rigidly ethical behavior and an insistence on addressing all details of his interpersonal relationships.³⁹⁸ The court dismissed his claim, finding that he was discharged because of his work performance and lack of collegiality.³⁹⁹ The court held that the University was not concerned about Newberry's mental illness.⁴⁰⁰ According to the court, this would require evidence that the University believed, for example "that mentally ill people are inherently dangerous, and they fired him to avoid the danger. . . ."⁴⁰¹ The court noted that when the employee engages in inappropriate behavior, even if that behavior was caused by the mental illness, the employer may fire the employee "as long as the collateral assessment of disability plays

394. 42 U.S.C. § 12113(b) (1994). *See also* Hubbard, *supra* note 172, at 1281 (discussing the direct threat defense). The Supreme Court has held that the direct threat defense applies when a person poses a direct threat to others *or* to him or herself. *Chevron USA, Inc. v. Echazabal*, 536 U.S. 73, 76 (2002).

395. 42 U.S.C. § 12112(b)(5)(A). *See also* Georgia A. Staton & Greg J. Thompson, *A Practical Perspective on Employee Violence and the Americans with Disabilities Act*, 35 ARIZ. ATT'Y 32, 34 (1999).

396. *Newberry v. E. Tex. State Univ.*, 161 F.3d 276 (5th Cir. 1998).

397. *Id.* at 278.

398. *Id.*

399. *Id.* at 279.

400. *Id.*

401. *Id.*

no role in the decision to dismiss.”⁴⁰² The court failed to see the connection between the plaintiff’s behavior, lack of collegiality, and his discharge.⁴⁰³ While the court recognized that stereotypes about mental illness could result in discrimination,⁴⁰⁴ it did not see that holding the plaintiff to the same standard of collegial behavior could also result in discrimination.

Similarly, Robert Steele began working for Thiokol in 1987 as a Rocket Test Technician.⁴⁰⁵ Sometime during his employment with Thiokol, he was diagnosed with depression, and then in January 1995, he was diagnosed with obsessive compulsive disorder.⁴⁰⁶ He was promoted several times during his first few years.⁴⁰⁷ He had difficulty, however, getting along with co-workers⁴⁰⁸ who would hum “If I only had a brain,” write the word ‘dunce’ on his hard hat, refer to him as ‘psycho Bob’ and as ‘a psychopath.’⁴⁰⁹ Mr. Steele complained to management on several occasions about being harassed by co-workers.⁴¹⁰ While his supervisor noted that the plaintiff was, in fact, teased more than other employees, he felt it was due to Mr. Steele’s being “obsessed with his planned litigation against Thiokol because he talked about it continually.”⁴¹¹ Mr. Steele’s co-workers were given training and Mr. Steele was told to stop discussing his lawsuit with co-workers.⁴¹² Mr. Steele got into an argument with his supervisor and a co-worker.⁴¹³ He then suffered a “nervous breakdown” and was absent for several weeks. He returned to work and was terminated one month later pursuant to a reduction in force.⁴¹⁴ Mr. Steele was the lowest rated employee in his area and was terminated after consideration of his “work performance, contributions to the team, disciplinary history and ability to get along with co-workers. . . .”⁴¹⁵ Mr. Steele filed a

402. *Id.* at 280.

403. *Phillips v. D.A.P., Inc.*, 10 F. Supp. 2d 1334, 1336 (N.D. Ga. 1998). *See also*, *Palmer v. Circuit Court of Cook county*, 117 F.3d 351 (7th Cir. 1997); *Harris v. Polk County, Iowa*, 103 F.3d 696 (8th Cir. 1996); *Maes v. Henderson*, 33 F. Supp. 2d 1281 (D. Nev. 1999); *Sullivan v. River Valley Sch. Dist.*, 20 F. Supp. 2d 1120 (W.D. Mich. 1998); *Houck v. City of Prairie Vill.*, 978 F. Supp. 1397 (D. Kan. 1997).

404. *Newberry*, 161 F.3d at 280.

405. *Steele v. Thiokol Corp.*, 241 F.3d 1248, 1249 (10th Cir. 2001).

406. *Id.* at 1250–51.

407. *Id.* at 1249.

408. *Id.* at 1250.

409. *Id.*

410. *Id.* at 1251.

411. *Id.*

412. *Id.*

413. *Id.*

414. *Id.*

415. *Id.* at 1252.

complaint alleging that he had been discriminated against on the basis of his disability, obsessive-compulsive disorder.⁴¹⁶ He argued that he was substantially limited in several major life activities including, walking, learning, sleeping, and interacting with others.⁴¹⁷ The court noted that other jurisdictions had reached different results on the question whether interacting with others is a major life activity.⁴¹⁸ The court sidestepped the issue, however, holding that even if interacting with others was a major life activity, the plaintiff was not substantially limited in his ability to get along with others; the plaintiff had only established that he had difficulty interacting with co-workers but not that he had difficulty interacting with people in general.⁴¹⁹ Accordingly, the plaintiff was not substantially limited in a major life activity and his claim was dismissed.⁴²⁰ Again, this put the plaintiff in a catch-22. Had he been unable to get along with anyone, he would not have been otherwise qualified for his job. Surely, there must be some population of people with mental illness that is both disabled enough to receive the protections of the ADA but not so disabled as to lose it by failing to be otherwise qualified.

The concept that people with a mental illness can be held to the same standard of behavior as people without such an illness has no support in the ADA. The ADA only mentions this idea with reference to people who are abusing drugs or alcohol.⁴²¹ Moreover, to hold people with a mental illness to the same standard of behavior as non-mentally ill people eliminates much of the protection Congress thought it was affording to the mentally disabled. While employers should not have to endure totally unacceptable behavior, this is not the same as holding someone with a mental illness to the same standard of behavior as others without a mental illness. We do not hold a hearing-impaired person to the same standard of hearing as people who are not deaf. We should not hold people with a mental illness to the same standard of behavior as the non-mentally ill.

416. *See id.* at 1252-53.

417. *Id.* at 1253.

418. *Id.* at 1254. *Compare* Soileau v. Guilford, 105 F.3d 12, 15-16 (1st Cir. 1997) (holding that the ability to get along with others is not a major life activity) *with* McAlindin v. County of San Diego, 192 F.3d 1226, 1234 (9th Cir. 1999) (holding that interacting with others is a major life activity).

419. Steele, 241 F.3d at 1255.

420. *Id.* at 1256.

421. The issue of whether this is justified for those abusing drugs or alcohol I leave to someone else or a later article.

VI. ELIMINATING THE DIVIDING LINE IN THE ADA

The ADA was enacted to “provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”⁴²² But it is important to understand that the law can only go so far. An anti-discrimination statute can affect behavior but it cannot eliminate the beliefs that underlie the behavior. Legislation cannot dispel the myths surrounding mental illness and it cannot eradicate irrational fears of violence. Much of the work to be done to eliminate the stigma and misunderstanding surrounding mental illness is not amenable to a legal solution.

That being said, it is at least the role of the ADA to insure that it does not contribute to the stigma and misunderstanding surrounding mental illness. While classification of illness is important to treatment, it may not be important under the ADA. For example, in order for a physician to properly treat someone having chest pain, it is important to know whether that person is having a heart attack or indigestion. In addition, the manifestations of disability are important in finding a reasonable accommodation. For example, if a person is hearing-impaired, it will be important to know the extent of the hearing impairment to determine what, if any, reasonable accommodation would be needed. Dividing the world of ADA protected disability into physical and mental serves no legitimate rationale and perpetuates the stigmatization of mental illness. Many suggestions have been made, including by me, for sweeping changes in the ADA or in its interpretation.⁴²³ But if the dividing line continues to exist, people with mental illness will still be in a second-class citizen status vis à vis physical disabilities. I, therefore, am making a more limited proposal here—that we amend the ADA to eliminate all distinctions between mental and physical disabilities. This would, at the very least, remove the bias from the wording of the ADA. It might also eventually pave the way to abolish the artificial dividing line between mental and physical disability, leading, in turn, to alleviating some of the prejudice and discrimination against mental illness.

The current statutory scheme of the ADA should be amended in four areas. First, all references to “mental and physical” should be

422. 42 U.S.C. § 12101(b)(1) (1991).

423. See, e.g., Samuel Bagenstos, *Subordination, Stigma & “Disability”*, 86 VA. L. REV. 397, 446–453 (2000); Korn, *supra* note 118, at 447–453.

eliminated. For example, the definition of a disability⁴²⁴ would become "The term disability means, with respect to an individual—(A) an impairment that substantially limits one or more of the major life activities of such individual." This is a small and subtle gesture. An argument can be made, however, that the Act's mention of both physical and mental disabilities is justified on the grounds that without the specific mention of mental disability, some might have been inclined to argue that it was not covered by the ADA. Given the prevalence of sanism, this possibility seems plausible. Moreover, because of the disfavored status of mental illness and our vision of a disability as a physical one, if all distinctions between mental and physical disability are removed, some would argue that this revision indicates that Congress did not want to cover mental illness. This leads to my second recommendation which is a strong statement by Congress regarding the purpose of the amendment which is to eliminate the distinctions between the two and not to endorse any argument that mental disabilities are not protected by the ADA.

Third, those behaviors specifically associated with mental illness that are presently excluded from coverage by the ADA should be deleted. Accordingly section 12111 (b)(1)–(3),⁴²⁵ with references to exhibitionism, voyeurism, compulsive gambling, and the other behavioral disorders should be repealed. There is no legitimate reason to exclude these behaviors that may (or may not be) associated with a mental illness. No physical illnesses are excluded. To exclude some behaviors that are more typically associated with a mental illness is, in and of itself, discrimination. The list of behaviors currently excluded from coverage by the ADA would seem to be a list of the most stigmatized people or the least socially accepted behaviors. Such an amendment would not, however, require that a fire department (or any other employer) hire a pyromaniac. Presumably, any fire department with knowledge of this condition could successfully argue that the pyromania was a direct threat to co-workers, or that it was a bona fide occupational qualification to not be a pyromaniac, or that it would be an undue hardship to accommodate such a condition.

Finally, the ADA should also be amended to add more inclusive examples of major life activities. As currently written, the

424. See 42 U.S.C. § 12101(2) (which currently reads "The term 'disability' means, with respect to an individual—(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual . . .").

425. 42 U.S.C. § 12111(b)(1)–(3).

regulations provide that major life activities include "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."⁴²⁶ Although this list is not exhaustive,⁴²⁷ it neatly captures the notion that basic physical tasks are really what distinguish people with disabilities from the rest of the population.⁴²⁸ Our image of what constitutes a disability is deeply entrenched in the physical. Note that when talking about the opposite of a disability, the term *able-bodied* is often used. It is important that those enforcing and interpreting the ADA understand that a disability can involve activities other than basic physical functioning. Thus, the examples of what constitutes a major life activity under the ADA can also be a vehicle for expanding our vision of what constitutes a disability. Activities such as (but not limited to) orderly cognitive thinking, the ability to get along with people, and the ability to react in an emotionally appropriate manner should be added.

Amending the ADA to eliminate the division between physical and mental disabilities will have both concrete and abstract benefits. Among the possible, more difficult to quantify benefits could be the reduction of stigma associated with a mental disability. As many disability advocates have come to recognize, much about a disability is socially constructed. Accordingly, many of the problems encountered by people who are mentally ill are not caused by their illness, but rather are caused by someone else's reaction to their mental illness.⁴²⁹ Because of the stereotype of violence, many people are frightened by the idea of working with someone with a mental illness.⁴³⁰ This employment problem is not caused by the mental illness itself but rather by an employer's reaction to a person with mental illness.⁴³¹ In this view, the problem for the person who has the mental illness is socially constructed. This view does not suggest that there are no employment issues caused by mental

426. 29 C.F.R. § 1630.2(i) (2000).

427. *Id.*

428. Although EEOC's Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities (2000) mentions other major life activities such as thinking, concentrating and interacting with others, courts have felt free to ignore these. *See, e.g., Breiland v. Advance Circuits, Inc.*, 976 F. Supp. 858, 863 (D. Minn. 1997).

429. WINICK, *supra* note 277, at 106; HIGGINS, *supra* note 105, at 28. Note that this does not mean that the mental illness causes no problems; it does mean that the reactions of others exacerbate many of the problems for people with disabilities.

430. *See supra* note 195.

431. *Id.*

illness but does suggest that many of those are imposed by others and not by anything inherent in mental illness.⁴³²

A more concrete benefit of these proposed amendments would be to help end the disparity in insurance benefits. Currently, according to the EEOC,⁴³³ plaintiffs cannot challenge a disparity in insurance benefits unless they can demonstrate that the insurance plan makes a "disability-based distinction." Moreover, according to the EEOC, distinctions between mental and physical disabilities are not a disability-based distinction.⁴³⁴ At present, EEOC defines a disability based distinction as one that, among other things, excludes a "discrete group of disabilities (e.g. cancer, muscular dystrophies, kidney disease)."⁴³⁵ The amendment of the ADA to eliminate the distinction between mental and physical disabilities would abolish the position taken by the EEOC and adopted by the courts.⁴³⁶ This would not necessarily require parity, however, because the "safe harbor" provision⁴³⁷ of the ADA also provides that insurers may classify risks according to a person's disability when it is based on sound actuarial principles.⁴³⁸ Thus, if an insurer provided less benefits for a mental disability than for a physical disability, the plaintiff could now challenge this as a disability-based distinction. If the insurer could provide the sound, actuarial principles supporting this differential treatment, the disparity would be lawful under the ADA. However, the insurer would have to produce evidence that the disparity was actually based on sound actuarial principles and not on its best guess that covering mental illness costs more. It could not base an argument on stereotypes about mental illness.

Although the law cannot automatically alter people's beliefs, it can alter behavior. Perhaps in time, if the behavior changes, the beliefs will follow. But even if beliefs do not change, amending the ADA to eliminate the distinctions between physical and mental disabilities would be at least a step toward reducing the second-class status of mental illness.

432. See, e.g., HIGGINS, *supra* note 105, at 28.

433. See discussion *supra* note 341 (regarding the safe harbor provision).

434. See, e.g., Gold, *supra* note 291, at 798-801; Giliberti, *supra* note 332, at 601-602.

435. U.S. Equal Employment Opportunity Comm'n, APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE, 109 DAILY LABOR REP. (BNA), June 9, 1993, at E-3.

436. *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (4th Cir. 2000); *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3rd Cir. 1998).

437. 42 U.S.C. 12201(c).

438. Gold, *supra* note 291, at 791.

CONCLUSION

There is no question that people with all kinds of disabilities are stigmatized, stereotyped, and discriminated against. The ADA was enacted to eliminate discrimination against people with disabilities. Many disability advocates have criticized the ADA, arguing that it has failed to live up to its promise.⁴³⁹ Although commentators have noted that the ADA has fallen short of the goal of protecting people with physical disabilities, little attention has been paid to employment discrimination on the basis of mental illness.

Mental illness is largely misunderstood. Although the causes of mental illness are still mostly unknown, many look at mental illness as a myth, as unworthy of belief, or as malingering. Many believe that people with a mental illness could be cured if they were only emotionally stronger, tougher or better people.

People with mental illness have encountered more than their share of stigma, stereotypes, and discrimination. Some of this is the same as that encountered by people with physical disabilities. But people with a mental disability face a double-edged sword. They are not only subject to the same kinds of stereotypes and discrimination that people with physical disabilities face, people who are mentally ill are also feared because they are assumed to be violent. Although recent studies indicate that most people with a mental illness are not violent, the fear remains widespread.

People with mental disabilities are the second-class citizens of the disabled community. This is caused not only by the profound stigma associated with mental illness but also by our vision of a disability as a limitation on physical functioning. It is a widely held vision. Think of your vision of someone with a disability. Your likely image is someone in a wheelchair or who is blind. The ability to react in an emotionally appropriate manner is probably not what you thought of. Try and imagine, whoever, how deeply your life would be affected if you lost this ability.

The vision of disability as a physical one is evident in the ADA, which distinguishes between physical and mental disabilities. This reinforces subtle stereotypes about mental disabilities and encourages the belief that mental illness is somehow not as real as physical illness. The vision of a disability as a physical one is also evident in the regulations interpreting the ADA and in court decisions interpreting the ADA. Moreover, the ADA is being used to preserve the

439. See *supra* note 21.

paradigm of disability as a physical one and to prolong discrimination against people with a mental illness. Thus, the ADA is being used to continue the current second-class status of mental illness.

Although many of the problems for people with mental illness are not amenable to a legal solution, the ADA must be amended to eliminate distinctions between mental and physical disabilities. Regardless of whether this distinction was ever justified, it makes no sense to distinguish between kinds of disabilities to determine who is entitled to the protection of the ADA and who is not. The ADA cannot solve all of the employment issues for people who are mentally ill, but it should, at the very least, stop perpetuating stereotypes about mental illness that only serve to foster discrimination. The time has come to make clear that mental illness is as real as physical illness, it is as worthy of treatment as physical illness and is as treatable. The time has come to stop legitimating the marginalization of mental illness.